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January 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Lifestyle, according to Health and Welfare Canada, is "staying in shape or getting fit through regular physical activity or it's going to seed.... it's getting out and doing something enjoyable or being bored." Our cover photo (Courtesy Canadian Government Travel Bureau) illustrates a form of physical activity that is becoming increasingly popular with people looking for more exercise ... skiing.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

Usually the start of a new calendar year brings with it an almost imperceptible rise in spirits. Somehow we always expect things to be a little better in the 12 months ahead. This year, however, as the world struggles to recover from an economic downturn, many people are having trouble being optimistic about what 1977 has in store. Among these people who find their expectations suddenly and drastically curtailed are the members of the Class of '76 — upwards of 150,000 young persons who graduated last year from Canadian universities, community colleges and other post-secondary institutions. The former editor of *Canadian Labour,* Roy LaBerge, writing in the September issue of the Labour Gazette, describes the employment prospects of this group as "possibly the worst facing any graduating class since the 1930's Depression." Along with the Economic Council of Canada and Statistics Canada, he holds out little hope of improvement in the situation until the 1980's. His observation that "almost everywhere graduates in education, nursing, and several other health professions are having trouble finding professional openings because of government spending cutbacks" is not news to nurses. Nor is it much consolation to realize that job prospects are also bleak for accountants, scientists, architects, architectural draftsmen, metallurgists, biochemists, corporate planners and market researchers, among others. Nor to read that most universities report "poor" to "non-existent" job prospects for Ph.D's. On page 10 of this issue, you can read what some of the provincial nurses' associations have to report on the current scarcity of nursing positions in their jurisdictions. Subjective opinions on a scattered regional basis are not an accurate way to measure under-employment but one would have to agree with LaBerge when he suggests that, at the very least, Canada is not tapping the potential ability of many graduates.

Nurses, in common with members of other occupational groups, invest many years and thousands of dollars in preparation for a career. When oversupply of manpower, personnel cuts and reduced turnover make it impossible for many of them to find jobs, questions inevitably arise about the quantity and quality of public manpower planning.

The problems inherent in attempts to achieve a balance between supply and demand for professional and skilled manpower, are numerous and extremely complex, involving as they do wage rates, lengthy lead times, basic forces of economic expansion and educational planning. Manpower policies must be coordinated with other public policies, including immigration, regional development and science policy.

It is not enough to simply adjust the enrolment in the educational institutions in which nurses are prepared. "Short run" solutions are not the answer. Dorothy Kergin, well-known Canadian nurse educator, summed it up this way when she addressed delegates to the recent national conference on the professions and public policy: "Before manpower planning in the health field can be carried out with any confidence, we must have a national and provincial consensus on what kind of health system we are going to have and how much we are willing to pay for it." She suggested that we begin by deciding on the most effective way of dividing our limited resources among primary care services provided by a multi-disciplinary team, solo medical practitioners, and highly specialized institutional services. She went on to cite a recent study that showed how one ambulatory medical clinic, by changing its traditionally organized services, was able to cut costs by $32,500 per 1,000 patients per year simply by complementing physician services with care by nurse practitioners.

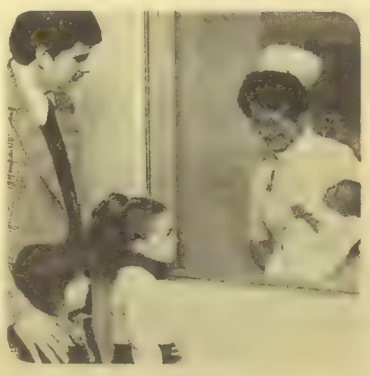
What are the assumptions behind our present nursing manpower forecasts? Does the answer to better utilization of our precious human and financial resources not lie in fundamental changes within our health care system — changes that involve allocation of authority and responsibility, methods of reimbursement and organization of delivery of services? Something to think about as we enter 1977, isn't it?

— M.A.H.

Herein

These days, as Alice pointed out, one must run very fast simply in order to stand still. **This month** CNJ celebrates the first anniversary of its new format by updating its cover design. We hope you approve. Why not drop us a line to let us know how you feel about it?

"Shared labor" is becoming an increasingly common occurrence in Canadian hospitals and even homes. Next month' author Linda Leonard describes the reactions of 20 husbands she interviewed shortly after they attended the delivery of their latest offspring. "The Father's Side: a



different perspective on childbirth" will offer nurses a little more insight into this aspect of their attempts to provide family-centered care.

A number of hospitals in Canada admit patients for **therapeutic abortions.** How are the needs of these patients for support and birth control counselling being met? This month author Bonnie Easterbrook describes the role of nurses in a unique counselling and support program available to patients admitted to Toronto General Hospital for therapeutic abortions.

Also this month, author Arlee McGee shares her thoughts on what nurses can do to improve their relationships with co-workers and' indirectly, contribute to the growth of the profession. **"The Nurse Continuum Perspective,"** which begins on page 24, is for every nurse who wants to understand herself and the people she works with a little better

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Nursing's true spirit

Thank you for your September article — Mary Berglund, Backwoods Nurse. In this day of increased emphasis on better salaries, working conditions, unions, strikes, etc., it's refreshing to know that the true spirit of nursing still remains alive in the hearts of people such as Mary Berglund.

Her story of dedication and unselfishness was appreciated by us and we are grateful for the privilege of having known Mary Berglund through the interpretations of a most sensitive author — Ingrid Bergstrom.

— Francis Ward, Halifax, N.S., Sybil Cameron, Middleton, N.S.

Emergency nursing

This is to point out the special interest arising from your article on *Understanding the Patient in Emergency* that appeared in the October 1976 issue.

Having some experience in the emergency ward, I have noticed the accuracy of your thinking on the lack of communication that exists between nurses and patients who are being taken care of in the emergency ward. Too often, the rapidity with which we must take care of a patient prevents us from noticing his state of anxiety and dismay.

We give too much importance to the physical treatments that must be administered promptly and we neglect the psychological and emotional aspects that have nevertheless an important therapeutic value.

On rereading this article, I have resolved to increase the human contact I have with patients in the emergency ward, as well as with the members of their families. For me, the emergency ward is the ideal place to work; this is the area that I feel most happy in and for this reason I really appreciate anything that can help my work—particularly with the patients themselves.

— Marie-Marthe Souliere-Roussel, Centre-hospitalier Sacre-Coeur, Hull, Quebec.

Our mistake...

In the article *Emergency Care of the Acute MI* in the November issue of *The Canadian Nurse*, the dosage for Xylocaine should read: Xylocaine drip 1 gm/500 ml. We apologize for our typographical error!

Single parenting

I have just read the November issue of *The Canadian Nurse* and again am proud of the credible articles this magazine presents to us. I am informed and touched with each issue but I am writing now in response to the article Operation Communication by Sharon Bala. I commend her integrity in accepting and searching for the vital aid, essential to the healthy development of so many of our children who, these days suffer loss.

I am the mother of six — three girls, three boys (five my own — one adopted) who was left to "raise, develop, and nurture" these children 11 years ago when the youngest was three years of age. I know the personal trauma and realize the damage that can be done along the way. It is not easy but the biggest growth in a human being is the realization that you have worked and achieved the development of your children. I am reaping this reward now as I see my family as individual, stable and most exciting people!

— Margaret Troyer, (née Graham), M.S.N., Ottawa, Ontario.

"Upside-Down" readers

I would like to compliment you on your questionnaire, (Oct., 1976) as an attempt to view the problems inherent in nursing ... We need to know how our colleagues feel on various issues. I would like to see questionnaires on issues such as the input nurses want to have as far as health care cutbacks etc., which focus on political concerns. It seems that nursing is so politically detached at the present time — such questionnaires may stimulate us to focus on meaningful issues again.
Vancouver, British Columbia.

I am very pleased to see such an item in our professional journal. At times I feel that *The Canadian Nurse* is written solely for and by the 'upper crust' of nurses .... For the floor nurses, the nurses who work shift, I congratulate you for your efforts and look forward to seeing the results of the questionnaire.
Etobicoke, Ontario.

...Would like to offer my congratulations to all the people involved in getting this magazine off the ground, and for the much-needed improvement in the last year...

...this questionnaire shows great initiative, and I hope the results will have some effect on the thinking of the health profession. If *The Canadian Nurse* continues to improve, it will rival the best this continent has to offer.

I hope this isn't just another survey — it's high time some concrete efforts were made to aid all night nurses.

Thank you. I enjoyed this — let's have more of these.
Lennoxville, Quebec.

I found your questionnaire very good, except that it seemed to take for granted that people do not like working nights, as shown by certain questions...

Editor's note: To these and all the hundreds of other readers who took time to contribute, not only through the questionnaire, but through their letters, many thanks. See also this month's Idea Exchange on page 46.

Quality or equality of life

... I wish to express my concerns about some recent medical trends ... We work together in one ward to terminate a life before birth — most of the time, a healthy one. At the same time, in an adjacent ward, we concentrate on saving a sick, handicapped premature baby who may need several surgical interventions before ever sitting on his mother's lap.

At least one Canadian hospital has switched from saline to prostaglandin abortions. This way, the baby is usually born alive, appears normal for the pregnancy stage, but too small to survive. This was upsetting to the staff witnessing the abortions and some nurses left their jobs. The hospital then chose to inject blue dye before the abortion. The nurses are now less upset because babies are blue when born (aborted) and look less like candidates for life. Where are our standards? We have abortions so that only "wanted babies" are born, so that their "quality of life" is assured. But what if the wanted baby, one day, becomes ill, or proves to be a "difficult child." Do we still want him?

Am I sure that I am a useful citizen; am I wanted by my family? Maybe not, yet I hope nobody decides to terminate my life just because someone doesn't want me around any longer. I am a Registered Nurse, but mostly,

— A concerned citizen of Canada, (name withheld).

O.R. experience invaluable

As head nurses and supervisors at a hospital in Eastern Ontario, we are concerned about the lack of knowledge and skills in relation to the basic principles of aseptic technique found in today's student nurse or new graduate. These remarks in no way reflect on the capabilities of the instructor or the caliber of the student: the students are knowledgeable, alert, eager to learn and they too seem concerned.

We feel that O.R. experience is invaluable and will reflect on the whole future of the nurse, no matter what field she chooses to follow. There is just no place where this can be truly learned except right in the atmosphere of the operating room, not just standing with your arms folded, but listening, learning and above all actively participating.

Please, before it is too late, put operating room nursing back into the curriculum and let us train interested nurses who could become future staff nurses or supervisors in our operating rooms.

— O.R. Supervisor, — — Hospital, (name withheld).

Our new look

...I have truly enjoyed the last three issues of *The Canadian Nurse* (September, October and November) and I wanted to let you know. My outlook and interest in *The Canadian Nurse* is changing.

— Cheryl L. Sutton, R.N., Victoria, B.C.

Just a short note to commend you on the great improvement in your articles. I used to just leaf through *The Canadian Nurse* ... now, each month provides a new learning experience. Keep up the good work.

— Dianne Brown, Ile des Chenes, Manitoba.

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Input

Discrimination still exists

The Advisory Council on the Status of Women would like to take this opportunity to remind nurses that every province in Canada now has human rights laws to protect its citizens against discrimination, but the federal government continues to delay passage of human rights legislation that has been promised since 1973. The Council points out that, as a result of this failure to act, discrimination *can affect* you and members of this association. For example:

If You Are a Member of a Minority Group, it means that services and accommodation can be denied to you because of your race or color.

If You Are an Older Worker, it means that employers under federal jurisdiction — such as banks, insurance companies, airlines and telephone companies — can legally refuse to hire you because of your age.

If You Are a Member of a Religious Group, it means that services and accommodation can legally be denied to you because of your religion.

If You Are a Woman, it means that you can be denied accommodation, services, employment, or equal opportunity for advancement. It also means that your employer can legally provide smaller pension and insurance benefits for you than for male employees.

Governments react to pressure from the public. If you, and thousands of people from across Canada, write to urge passage of human rights legislation, the government *will* act. You can help by writing today to Justice Minister Ron Basford, House of Commons, Ottawa, KIA 0A6, with a copy to your member of parliament. (No postage required).

Sample Letter

I strongly urge quick action by the government to pass the federal human rights act. I am a member of the Canadian Nurses Association and I object to the fact that discrimination on the basis of race, color, religion, age, sex and marital status is still legal under federal law.

— Yvette Rousseau, Chairman, Advisory Council on the Status of Women, Ottawa.

Jobs for the older nurse

There seem to be no job opportunities for nurses 50-60 years old that would permit us to maintain our competency within the limits of our strength due to aging. For example, 'twinning' could be made available. Income tax incentives alone make this attractive. We can handle four hours' work and still have the satisfaction of involvement. With health care budget cuts, administration should be interested in this idea.

Our experience here and overseas makes us valuable. Responsibility is 'water off a duck's back' to us. Disease has changed very little ... neither has basic treatment, nor understanding of the patient, nor hospital procedures.

We can cope. Doctors are often our age and so are many patients. Rapport is good. We are good house mothers. Often we are mothers and grandmothers. We can handle problems. The years have provided the answers.

Often we are given night duty. Aging leaves us needing less sleep but makes adjusting difficult. On changing shifts we have the dubious pleasure of a few days of no sleep.

I know our younger graduates need work but the job picture changes quickly. Throughout the whole nursing spectrum, I would like to see such job opportunities provided.

— Rita Bitten, R.N., Victoria, B.C.

Did you know ...

The nursing staff of St. Joseph's Hospital in Hamilton, Ontario has developed instructional manuals for diabetic patients. The manuals, entitled *An Instructional Aid for the Adult Diabetic* and *So You Have Diabetes (A Paediatric Diabetic Manual)* are intended to reinforce the individual teaching provided for diabetic children and adults. Copies of the manual are $1.00 and are available from:

Department of Nursing, St. Joseph's Hospital, 50 Charlton Ave. East, Hamilton, Ontario, L8N 1Y4.

Not just an aide

I am one of many Nurses' Aides in Canada. We are responsible for our guests in every respect: their health habits, cleanliness, comfort, contentment. We must be observant because we must report to our head nurse, so she will know what has been going on during that shift. RN's, RNA's both have their special magazines and books; they have their conventions and unions, but what do we have? Nothing. We have no say in hospital decisions, we have no books, or magazines. We are a forgotten part of the nursing profession. How many mental and nursing homes would have to close down for lack of staff if it were not for Nurses' Aides?

I wonder if the professionals and the men and women on the board of directors ever think that perhaps we have a home to keep up, food to buy, bills to pay. Maybe our pay check is the only one coming in.

We are *not* just Nurses' Aides, we are the bridge between the RN's, RNA's, doctors and the patients. We are the ones the patients or guests rely on, ask things of, depend on. We would like to feel that perhaps professionals could try to see the importance of the work that we do, and accept us as a necessary part of the nursing profession, not *just* an aide.

— (Name withheld), Cumberland County, N.S.

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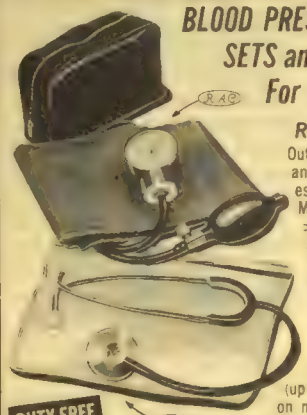
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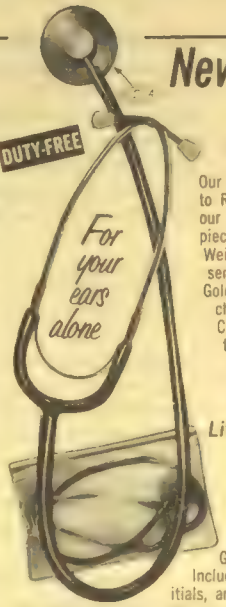
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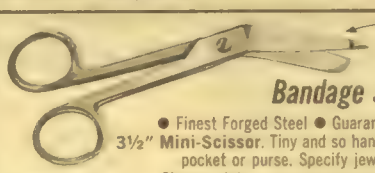
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News

Health educators examine alternatives to current system

Health science programs must change radically to provide health care workers with the kind of education they need to promote and adapt to changes in society's use of their services. This theme dominated the discussion at the Health Educators' Meeting during the 6th Annual Meeting of the Association of Canadian Community Colleges, held in Ottawa this November. The session centered around the problem of "Decreasing Enrollment — the Dilemma of Health Science Programs."

In confronting the question of whether health educators have a moral responsibility to decrease enrollment in response to decreasing need, Jenniece Larsen, chairman of the Allied Health Department at Grant MacEwan College in Edmonton, pointed out that we must distinguish between *real* health needs and artificial or created needs which depend on the economic climate or on government priorities. In our society health standards are measured in terms of the number of doctors, hospitals and hospital beds, not in terms of home care, nutrition and our approach to geriatrics, and health programs tend to reflect this bias, she said. She suggested that a better question health educators might ask themselves is "Do we have a continuing need for nurses whose expertise is in the hospital?"

Larsen said that "health programs are too restricted in their focus if education is matched to specific job needs in society," and proposed that what is needed is a broad-based education system that provides graduates with the perspective to assess where needs are and the flexibility to change and work where they are needed. She added that health care workers also need to develop political skills to be able to lobby more effectively for shifts in government emphasis to where health needs really are.

Dr. Sheila Thompson, Director of Health Services at Douglas College in New Westminster, B.C., also addressed herself to the need for alternatives in discussing how education can change the utilization of its graduates. She compared our approach of relying heavily on credentials to the Chinese approach where effort is spent identifying people with the qualities needed to perform a job well and then training them to do that job and only that job. One problem with the credential approach is that we screen out many students who may have a high proportion of the personal qualities necessary to be a good nurse by requiring that they be able to understand and learn things they will never use on the job. One way of overcoming this problem is to develop a core curriculum for all health care workers which would provide them with the knowledge they can use at one level and also with the base to go on to higher levels of specialization. If this system were adopted, continuing education would have a greater and greater role to play in career mobility, she said. The ideal would be a situation in which a licenced practical nurse with several years experience could move up the ladder to higher levels of specialization without starting over again, by taking courses to upgrade her knowledge and skills. At the same time she would be given credit for her experience.

Thompson proposed an alternative health care system in which clients would consult a paraprofessional, someone less trained than a doctor, for their basic needs, and be referred to a specialist if necessary. For this kind of team cooperation, medical workers must be trained together, she said.

To deal with problems like this that are related to health education in the community colleges, the ACCC set up a Health Education Resource Committee three years ago. One continuing problem that has been addressed by the committee and taken up by a Joint Committee of health educators from ACCC and AUCC (the Association of Universities and Colleges of Canada) is the question of accreditation. This cooperation has resulted in a major proposal to Health and Welfare Canada for an independent national Council on Accreditation of Health Science Educational programs.

ICN welcomes student nurses

The International Council of Nurses has announced that special accommodation for student nurses will be available during the 16th Quadrennial Congress, May 30 to June 3 in Tokyo. The Olympics Memorial Youth Centre has been set aside for the use of student nurses during the meeting.

To be eligible, students must be enrolled in an approved school of nursing in this country. Registration forms for students are available from the Canadian Nurses Association and must be signed by the president or executive director of the CNA.

The student nurse Congress registration fee, as stated on the registration form, is U.S. $30. before March 1, 1977 and U.S. $50. from March 1-31, 1977. No registrations will be accepted after March 31, 1977 and there is a cancellation fee of U.S. $20.

Testing Service Committee Approves Blueprint

The Canadian Nurses Association Committee on Testing Service has placed its stamp of approval on a blueprint for a comprehensive examination that will eventually replace the RN's now written by nursing graduates across Canada. The blueprint for a comprehensive exam, to be made available in both French and English, is the work of an eight-member CNATS committee set up by the Testing Service in 1975.

Myrtle Kutschke, Blueprint Committee chairman, and Michelle Charlebois, committee member, presented the committee's final report to the Committee on Testing Service (COTS) at a meeting at CNA House in mid-November. COTS members voted unanimously to accept the blueprint.

The next step in the development of the comprehensive exam will be the convening of committees to write objectives for the blueprint. These objectives will form the basis for development of test items. Four objectives committees have already been appointed for each language. Eric G. Parrott, Director of Testing Service, says that the first meeting of these committees is scheduled for January 24-29, 1977, with other meetings to follow in February and March.

Nurses to complete new health forms

The National Council of the Girl Guides of Canada has approved a new Health Evaluation form for Girl Guides attending activities in Canada and the United States which may be completed by a registered nurse with provision made for referral to a physician if necessary. The request for a health assessment form which could be signed by a registered nurse came to the Canadian Nurses Association from the National Camp Commissioner of the Girl Guides of Canada in November 1975. The disease-oriented evaluation report used at that time was felt to be too detailed and required the signature of a physican, which during the busy summer months was difficult to obtain. In response to the request from the GGC, the Canadian Nurses Association formed a committee of nurses skilled in health assessment and subsequently developed a concise health evaluation form designed for total health assessment. Only essential information required by a registered nurse in completing a health evaluation was included.

This form which must be completed three days before a Girl Guide attends camp or other activity will be in circulation by early spring.

NBARN supports provincial consultant in psychiatric nursing

The New Brunswick Association of Registered Nurses has pledged full support for improving standards of mental health and psychiatric care in New Brunswick. The Association's Council voted in November to request government support for a provincial consultant in psychiatric nursing, and called on all groups concerned to work together in upgrading standards.

The action was taken after reviewing a report on the six-month advanced course in psychiatric nursing held earlier this year. Twelve nurses graduated from the course, which was co-sponsored by the NBARN and the Department of Health.

NBARN president Simone Cormier said that the Council agreed with the Report's major recommendation for a nurse at the government level to upgrade psychiatric nursing in New Brunswick. Such an appointment would maximize the positive strides taken in the field of mental health, particularly over the past few years, she said. Because patients with psychiatric disorders are being treated in their own communities through such programs as community mental health clinics, psychiatric units in general hospitals, and discharge of patients from the large provincial institutions to foster homes, there is a need for a nurse at the government level with expertise in mental health/psychiatric nursing care. Cormier said, "We see this as a priority in the total scheme of providing improved services for psychiatric patients."

Did you know...

An experimental treatment for **multiple sclerosis** will be tried out on eight patients in Toronto soon. The patients, who are under 35 years of age, who have had MS less than five years, and who are experiencing an acute relapse, will be given protein injections. If these patients are not helped, the experiment will end, but if results are encouraging, 17 other patients will receive the treatment before evaluation of the experiment.

McGill Research Unit to study community health nursing

The Research Unit of the School of Nursing, McGill University, has been awarded a National Health Research and Development Award for the funding of a Demonstration Project involving the establishment of a community health nursing service. The project, located in a middle income suburban community of Montreal, is directed toward the development and maintenance of family health in a primary care setting.

Some unique features of this setting differentiate it from existing experiments in community health centers. For example, it will serve a middle income group as opposed to a disadvantaged sector; it will provide a nursing service supported by community development and information services; physicians will not be located within the center but will be utilized whenever medical consultation and/or referral is required; emphasis will be placed on the workshop nature of the setting — a place in which people — individuals, families and groups, will come to work on and learn to deal with problems related to health.

As they provide care, in collaboration with McGill School of Nursing, the nurses involved in the project will be exploring, learning and demonstrating new ways of nursing families and a community toward health. In addition, emphasis will be placed on the development of a design for evaluation.

The Research Unit at the McGill School of Nursing has only recently been established and has four nurse researchers, seven researchers from other disciplines and a number of research assistants on staff. Besides this community health project, the Unit is also investigating the learning of health behavior in children.

Development of the Research Unit in nursing and health care permits the School of Nursing to offer graduate nurses the opportunity to prepare themselves as researchers at the Master's level. The program is two years in length and financial support of up to $5,000 per year is available through the Research Directorate of Health and Welfare Canada.

CNA executive director receives Rcn Honorary Fellowship

A Canadian was among ten nurses elected by the Royal College of Nurses of the United Kingdom to receive official recognition during the College's Diamond Jubilee Year. Helen K. Mussallem, executive director of the Canadian Nurses Association, was the only nurse from outside the United Kingdom to receive an Honorary Fellowship from the College in a special ceremony in London, England on November 24.



The occasion marked the first time in the 60-year history of the College that it exercised its power to confer Fellowships and Honorary Fellowships in recognition of exceptional contributions to the advancement of the art and science of nursing. The Honorary Fellowship awarded to Dr. Mussallem was conferred by the College in recognition of "her work at international level in advancing nursing education and high standards of nursing practice."

Winifred E. Prentice, immediate past president of the Rcn and chairman of the committee on fellowships, read the citations and presented the insignia and scrolls of Fellowship or Honorary Fellowship to the recipients. The citation to Dr. Mussallem described her as "Canada's most distinguished nurse in her generation" and pointed out that: "She can equally well be described as a nurse of the world, so generous has she been in accepting overseas assignments under the aegis of the World Health Organization and of other governmental and non-governmental bodies, also in responding to individual calls from the profession in various countries wishing to benefit from her vast knowledge of nursing education and deep understanding of the nursing process."

Above, left to right, Catherine Hall, Rcn executive secretary, Helen Mussallem, and Winifred Prentice are pictured following ceremony. Eligibility for consideration for Fellowships requires nominees to be members of the College, actively engaged in practice. Honorary Fellowships are awarded to Rcn members who have retired from practice or to nurses who have made an exceptional contribution to the advancement of nursing at the international level but are not eligible for Rcn membership.

News

Coast-to-coast reports indicate few nursing positions available

Eight months ago, in May 1976, *The Canadian Nurse* conducted an informal survey of CNA member associations throughout Canada in an attempt to obtain a national overview of the nursing manpower situation in the various jurisdictions. At that time, we reported that the general picture was one of tightening up in employment prospects, with pockets of serious unemployment becoming apparent in several centers. In anticipation of another wave of graduates entering the employment picture within a few months, CNJ has attempted to up-date information presented at that time. Here is what spokesmen for the various provincial/territorial member associations have to report:

Newfoundland
Almost all of the 1976 graduates from Newfoundland Schools of Nursing have nursing positions (fewer than ten do not have jobs). Most of the smaller hospitals across the province are staffed as budgets permit, but hospitals or nursing stations in approximately six to eight more remote areas of Newfoundland and Labrador still require experienced nurses. Officials in hospitals outside the larger centers report much less difficulty this year in obtaining nursing staff. There are several nurses listed with the Canada Manpower offices across the province.

A total of 30 nurses are presently listed as required by employers. Most require experienced nurses and most are needed in the smaller areas, and in extended care facilities. Many of the part-time positions have been filled by full-time personnel. Openings are available for public health nurses in a few areas.

Most Schools of Nursing did not decrease enrollment of nursing students this fall (to any degree) but immediate consideration will have to be given to this.

New Brunswick
As far as job vacancies and nursing manpower are concerned, the saturation point reached in the spring continues to exist. As a result, the in-migration of out-of-province (mainly Ontario) nurses experienced earlier this year has decreased.

There are a substantial number of nurses across the province looking for employment through Canada Manpower, and hospitals and agencies employing nurses continue to enjoy a period of adequate staffing.

Nova Scotia
In August we had 359 new graduate nurses. As far as we can determine, 167 of these are now employed —most in Nova Scotia but some in the States.

In June of this year we conducted a survey of all our R.N.A.N.S. members who said that they were unemployed at the time of registration. Considering those on U.I. benefits, our Placement applicants, the unemployed new graduates and those who appear to be unemployed as of the June survey, we estimate close to 800 unemployed nurses in the province. The vacancy situation is not very good. We only have two vacancies in hospitals and nursing homes in the month of September. Before the restrictions were imposed on the hospitals last January, we could expect approximately 40 vacancies monthly in the metro area. This year nurses are hanging on to their jobs and as a result, we are not sure if this figure will remain the same.

We do expect approximately 80 new jobs next spring when two new hospitals and two new nursing homes open. However, one of the hospitals employing approximately 50 nurses expects to close.

Ontario
The employment situation for nurses in Ontario has not changed drastically from an oversupply situation.
The R.N.A.O. Referral Service officially began operation on October 1, 1976 and the first survey to over 1,100 agencies employing nurses indicated that there were 135 positions available . Of these positions, 30 were part-time and 44 were anticipated openings. General hospitals listed 62 positions — 34 at the management level and 28 in specialty units where special preparation was required. There were very few openings in Public Health or educational facilities. Many of the part-time positions were listed in Nursing Homes and Homes for the Aged. The majority of available positions were clustered within the larger cities of Ontario.

A survey conducted by the Ontario Hospital Association in June 1976 shows that of 1,193 hospitals reporting, there were 208 R.N. vacancies.However the openings were in specialty areas and/or requiring nurses with special preparation.

Canada Manpower Centre's data indicates that in July 1976, of 1,560 employees laid off from hospitals, 70% were registered nurses. A program to assist the employers and employees was initiated with some success. They have found that most employees do not have the mobility to move to other jobs in other areas, and that where the number unemployed is high — is also an area or city with few or no nursing job opportunities.

In terms of the approximately 3,200 new graduates from the College of Applied Arts and Technology, success rate in finding jobs varies from college to college. In mid-summer the number with jobs ranged anywhere from 7 to 50 percent, and roughly half of the positions accepted were in the United States.

Prospects for the next few months do not appear to be any different. The province is awaiting the court's decision on the hospital closures, and announcement of government policy on financing for 1976.

Manitoba
We know that some of the new graduates who wrote CNATS exams in August are not employed and that for each general staff position, there are many applications. We also have several administration positions and positions in specialty areas not yet filled.

A more detailed report will be available following establishment of our referral service.

Alberta
Employers state that the turnover rate of registered nurses is beginning to pick up slightly. Vacancies, however, are being filled from within the health agencies, as part-time and casual employees move into permanent positions. Applications for employment in most situations are adequate, the exception being in the north of the province. A dearth of nurses exists where expertise is required, both in education and experience. The primary need is Intensive Care personnel.

Saskatchewan
It is difficult to know accurately the supply of nurses in Saskatchewan at this time. A brief survey was done at the end of September and we found 83 new graduates unemployed at that time. Some of the employed had employment in areas other than nursing. Like other provinces, we believe that some nurses have left and others will be leaving to take nursing positions in the United States.

Many nurses who have come into the province from other countries have had difficulty in passing the registration examinations. Consequently some of these are now unemployed and are having difficulty in finding suitable employment.

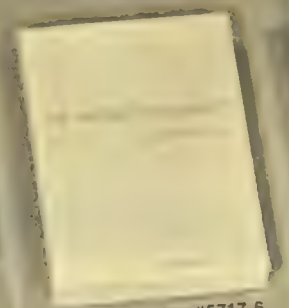
Northwest Territories
In the N.W.T. there are very few jobs open. Most hospitals (Inuvik, Hay River, Yellowknife, Frobisher, and Ft. Smith) seem to be able to meet their requirements with ease. The Federal government also has very few openings in the Nursing Stations. The nurses required for the Stations must have experience and/or additional preparation (i.e. Nurse Practitioner Course).

We generally fill our staffing requirements with applications on-hand from interested persons. Few of the hospitals advertise for staff. We did feel that the number of applicants, with good references and with experience has increased over the last few months. Many are from Ontario where the impact of closed hospitals must be being felt.

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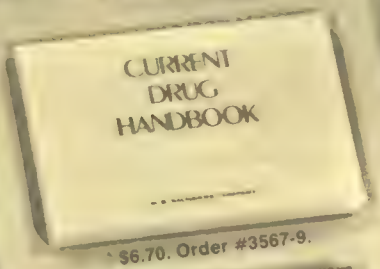
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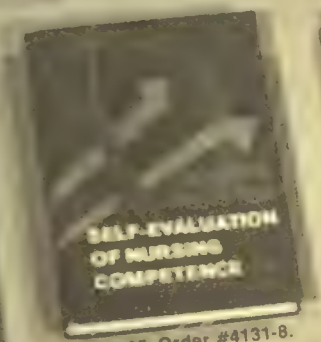
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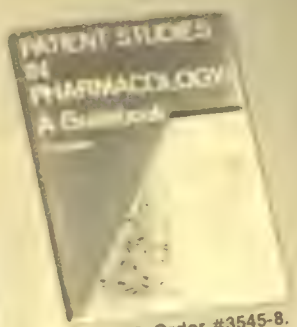
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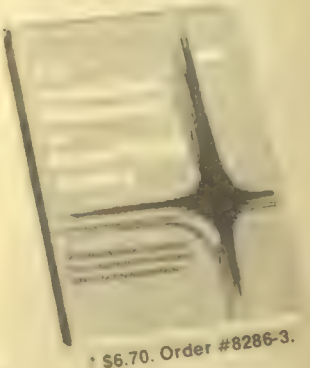
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News

MARN sets up referral service

The Manitoba Association of Registered Nurses has set up a referral service for RN's to assist both nurses seeking employment and employers seeking nursing staff.

Health agencies in the province are providing the Manitoba Association of Registered Nurses with up-to-date listings of staff vacancies. Registered nurses looking for work who contact the MARN office will be given a list of vacant positions, and may then apply directly to the agency of choice.

The referral service is not a placement service and recommendations are not provided either to the nurses or to the employer. The decision to apply or to hire is left to the nurse or the agency. A list of several full-time nursing positions outside of the city of Winnipeg is now available.

Nurse heads N.W.T. Public health association

Janet Lindquist, R.N., who is Nursing Consultant for the Northwest Territories Health Insurance Service was recently elected the first president of the N.W.T. Branch of the Canadian Public Health Association. The first meeting of the branch, with Dr. Ken Benson, national president of the Canadian Public Health Association in attendance, was held immediately following the Twelfth Annual Meeting of the N.W.T. Hospital Association in Hay River, N.W.T. on November 24 and 25, 1976. The theme of the meeting was 'The Community Health Center' and in conjunction with the main session, seminars in Nursing, Housekeeping and Dietary Services were held.

Guest speaker at the Nursing Seminar was Beverly Rinneard of the Scarborough Centenary Hospital in Toronto who presented information on the Bedside Audit and its relationship to nursing standards to about 20 nurses from Yellowknife, Hay River, Ft. Smith, Ft. Simpson and Ft. Rae. She also discussed the use of the Friesen concept as implemented in her hospital and gave assistance to the Hay River hospital which is in the process of implementing the Friesen Concept in the new Health Center.

Ontario PHN's hold second open forum

Sexually transmitted diseases, diseases of the jet age, home births and the need for more nursing research were the four issues that occupied the attention of more than 100 of Ontario's public health nurses at a recent day-long seminar in Toronto. The occasion was the second open forum for public health nurses sponsored by the Registered Nurses Association of Ontario.



Speakers included Elaine Hykawy (above) of the Ontario Ministry of Health; Christina Butler (below) of the Victorian Order of Nurses of Metropolitan Toronto; Gail Wright of the Ontario Ministry of Health and Joyce Kinslow of the Etobicoke Health Unit. Chairman for the event was Margaret M. Boone.



Photos courtesy Suzanne Emond

Notice of Annual Meeting of the Canadian Nurses Association

In accordance with By-law Section 44, notice is given of an annual meeting to be held 31 March 1977, commencing at 09:00. This meeting will be held at the Chateau Laurier Hotel, Ottawa, Ontario. The purpose of the meeting is to conduct the business of the Association.

Ordinary members of the Canadian Nurses Association are eligible to attend the annual meeting. Presentation of a current provincial/territorial membership card will be required for admission. Students of nursing are welcome as observers. Proof of enrolment in the school of nursing will be required for admission.

Helen K. Mussallem, Executive Director,
Canadian Nurses Association.

International authorities to address ICEA conference on the family

Anthropologist Ashley Montagu heads the list of speakers scheduled to address the Fifth Canadian Regional Conference of the International Childbirth Education Association in Edmonton in June. The meeting is sponsored by the Edmonton Childbirth Education Association. Concerned professionals and lay persons from all across Canada, the northwestern U.S.A. and Alaska are expected to attend to obtain information and insight to help them in their own fields.

The theme of the conference is *Nurturing the Family.* The program will incorporate findings from medicine, mental health, sociology, and many other fields to form an integrated approach to the care of the normal childbearing family.

Program participants include, in addition to Montagu, who is the author of "Touching" and "Life Before Birth": Niles Newton, behavioral scientist specializing in the psychological aspects of child-rearing and reproduction; Elizabeth Bing, author, childbirth educator and co-founder of the American Society for Psychoprophylaxis in Obstetrics; Agnes Higgins, executive director of the Montreal Diet Dispensary; and Wilma Marshall of La Leche League, Edmonton.

Topics to be discussed during the meeting include: early parenting; the role of the health care administrator in delivering family-centered care; overview of modern obstetrical practice; drug use; high-risk mothers; breastfeeding; meeting the needs of native people; temperament of babies; obstetrics and the teenager; the advisability of adoptees tracing their natural parents.

Lawyers, sociologists, doctors, nurses, and psychologists are among the professionals expected to participate in the conference.

ICEA is an interdisciplinary organization, founded in 1960, representing a federation of groups and individuals, both parent and professional, who share a genuine interest in parent education and family-centered maternity care.

The Edmonton Association was founded in 1967 and joined the International Association in 1974.

Resolutions for Annual Meeting

Members who wish to submit resolutions to the Canadian Nurses Association annual general meeting (31 March 1977) are asked to send them to CNA House by 1 February 1977 to ensure distribution.

Helen K. Mussallem, Executive Director,
Canadian Nurses Association.

Code of Ethics implemented in Quebec

After two years of intensive work and of consultation between members of the Order of Nurses of Quebec and the Office des professions, nurses in the province of Quebec now have their own Code of Ethics. The Code was conceived as an effective instrument to enable the Order of Nurses of Quebec to fully assume its role as the protector of the users of all nursing care services in Quebec. It came into effect at the end of September last year.

The following is a list of the principal subjects dealt with in the document:

- duties and obligations towards the public
- duties and obligations towards clients
- integrity
- availability and diligence
- liability
- independence and disinterest
- professional secrecy
- accessibility of records
- determination and payment of fees
- derogatory acts
- relations with the Order and other members of the Order
- contribution to the advancement of the profession.

The Order of Nurses of Quebec invites readers who would like to obtain a copy of its Code of Ethics or wish to know more about its contents, to contact:
Monique Foisy, Public Relations Officer, ONQ, 4200 Dorchester West, Montreal, Que. H3Z 1V4.

Health happenings in the news

An American city — Washington, D.C. — has become the first in North America to record a higher number of **legal abortions** than births among its residents over a 12-month period. The human resources department of the city of Washington reports that a total of 9,819 abortions were performed in 1975, compared with 9,746 births. About 85 percent of the total number of abortions were paid for by the government Medicaid program for low income persons (7,417) or were performed without charge at the city-operated D.C. General Hospital (1,082).

A statistician at the London School of Hygiene and Tropical Medicine estimates that the risk of death from high blood pressure for women using **oral contraceptives**, compared with non-users, is 5-to-1. For all cardiovascular diseases, the ratio is 3-to-1.

Dr. Valerie Beral, author of the study indicating a stronger than suspected link between the contraceptive pill and diseases of the heart and blood vessels, bases her findings on an examination of morbidity statistics for 21 nations provided by the World Health Organization.

She found that as the availability of the pill rose, so did deaths due to cardiovascular disease in women aged 15 to 44. Dr. Beral estimates that as many as 200 additional annual deaths per million from heart and blood vessel diseases among women in this age group may stem from use of the pill.

Vaccination of native people in the North West Territories against swine flu got underway several weeks ahead of centers in the south because of the special threat the disease poses in the North. Native people, according to the territories' chief medical officer, Dr. F.J. Colvill, were isolated and not affected by the 1918-19 outbreak of swine flu and, also, "have historically been vulnerable" to respiratory tract infections such as influenza which is frequently followed by lung complications.

"Northern natives lack protective antibodies to help fight off the disease," Dr. Colvill said. He added the limited hospital capacity in the region would require "mass evacuations should an epidemic of any magnitude develop."

The vaccine is being made available at nursing stations and health units throughout the N.W.T.

While the federal Advisory Council on the Status of Women calls existing **birth planning programs** "inadequate" and recommends more government spending on family planning information and services, the federal government has been cutting back expenditures in this area. According to members of the advisory council, comprehensive family planning must become "a matter of high priority" for federal and provincial governments, a matter important enough to justify increased use of public funds.
the Department of Health and Welfare says that the budget for printing and distribution of information has been cut, that staff has been reduced, and that budgets for training and research projects in Canada have not expanded according to the increase in the number of projects.

A new Environmental and Occupational Health Unit is to be set up within the Faculty of Medicine of the University of Toronto. The goal of the unit will be the solution of a wide range of health problems caused by environmental pollution and the effects of industry on the employee. The focus will be on research, education, information and consultative services.

An **Oncology Nursing Society,** of special interest to nurses concerned with the variety of modalities of treatment of cancer patients, is now operating in the greater Montreal area. The Society is open to all nurses in the province of Quebec.

Its primary goals are:

- to promote quality care for cancer patients
- to act as a support group for one another in cancer nursing.

Officials include: Jennie E. MacDonald, RN, head nurse, Oncology Day Center, Royal Victoria Hospital, (president); Frances Murphy, RN, head nurse, Montreal Neurological Hospital, (vice-president); Heather Dorsey, RN, head nurse, Royal Victoria Hospital, (secretary); Elizabeth Scott, RN, chemotherapy nurse, Queen Mary Veterans' Hospital, (treasurer).

Society president, Jennie E. MacDonald, points out that the Quebec group is anxious to offer assistance to nurses in other provinces who would like to form a similar society. The group also invites applications from interested nurses in Quebec who have not yet joined the Society to contact the president c/o the Royal Victoria Hospital, 687 Pine Avenue West, Montreal, Quebec, H3A 1A1.

M.Sc.(Applied) offered to non-nurses

The Kellogg Foundation has awarded a grant to the School of Nursing, McGill University, to fund a new 3-year program offered to non-nurses holding a B.A. or B.Sc. degree and leading to a Master's degree in Nursing.

The first year is a qualifying year, in which students are provided with experiences fundamental to the practice of nursing. The two final years are in the regular M.Sc. (Applied) program, in which a broad nursing base is developed and refined. Nurse licensing examinations are written toward the end of the third year.

Further information about the program may be obtained by writing to: McGill University, School of Nursing, Master's Program, 3506 University Street, Montreal, P.Q.



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PETER: an infant with a myelomeningocele

Judith M. Hendry

Myelomeningocele is a congenital defect that occurs in as many as three of every 1,000 children born. The problems facing the infant with this condition and his family are illustrated in this case study of one nurse's experience in caring for Peter and in supporting his family.

"Is the baby normal?" This is often the first question a mother will ask about her newborn child. In the excitement of the event, how difficult it is to have to tell the parents that their baby is not alright — that he has a serious defect.

Peter was the firstborn son of twenty-two-year-old parents. As with any young couple, they had been anxiously awaiting the birth of their baby and had received no warning that their baby might not be normal. Peter was born with a severe midlumbar myelomeningocele which extended from the second to the fifth lumbar vertebrae. Immediately following his birth, he was transferred by ambulance to The Hospital for Sick Children, Toronto for better evaluation of his condition. His mother stayed in hospital for a week before she was able to visit him.

Specific nursing interventions were implemented based on a systematic assessment of Peter's physical status and his parents' coping abilities.

Peter

Physical Assessment

Only a few hours after his birth, Peter arrived on the surgical infant area where I was working. He was in no apparent distress although he had mild peripheral cyanosis. His vital signs were within normal limits; his pupils were equal in size and reacted briskly to light. Although his head was not enlarged (a circumference of 35 cm), it was significantly moulded and the fontanelles were large and soft. He had a strong, lusty cry.

On examination, his skin was soft, clear and pink. The myelomeningocele was covered by a thin membrane and was oozing a small amount of serosanguinous drainage.

Rooting, sucking and grasping reflexes were present. When I stroked Peter's cheek, he struggled to turn his head towards me. He displayed a good grasp reflex with his fingers but his lack of response to the pinprick test below the level of the second lumbar vertebra indicated that there was no apparent motor or sensory function in his lower extremities. The hip flexor muscles had some tonus but the abductors and extensors of the hip were paralyzed, causing flexion, adduction and lateral rotation deformities of the hip and extension of the legs. A slight rectal prolapse indicated poor tonicity of the anal sphincter. He was able to void a good stream of urine spontaneously, but his bladder was not emptying completely and retained approximately 10 cc of urine. Peter also had bilateral clubfeet with calcaneous, equinovarus and "rocker bottom" deformities.

Treatment

Less than 12 hours after his birth, after a thorough medical/ surgical assessment of his condition, Peter underwent surgery for repair of the myelomeningocele. Under general anesthetic, the membrane was excised exposing the neural plaque. The meninges were sutured over the plaque in the midline, and lateral skin flaps were raised and sutured over the meninges. Postoperatively, Peter's condition was stable and he was nursed prone with a dry elastoplast dressing over the incision.

Associated Problems

Approximately 80-90% of infants with myelomeningocele develop hydrocephalus.[4,5] Tension or fullness of the fontanelles and increasing head size are early indicators of the increased intracranial pressure associated with this condition in infancy.

Signs of Increasing Intracranial Pressure in Infancy

- tense or bulging fontanelles
- restlessness, irritability
- lethargy
- drowsiness
- increasing head circumference
- sutures palpably separated
- vomiting
- sluggish, unequal response of pupils to light
- decrease in apical rate

Thus, it was important to check the tension of the fontanelles, pupillary reaction and level of consciousness when taking Peter's vital signs. His head circumference was assessed daily by placing the tape measure snugly around his head from the occiput to the frontal region just

FIGURE I myelomeningocele



Myelomeningocele is a severe defect in which there is failure of the two halves of the vertebral spinous processes to fuse posteriorly, creating an incomplete neural arch.[1] A sac composed of the outer meninges (dura and arachnoid membrane) and filled with cerebrospinal fluid, protrudes through the bony defect. Neural tissue is encapsulated in the sac and is usually flattened in appearance (see Figure 1).

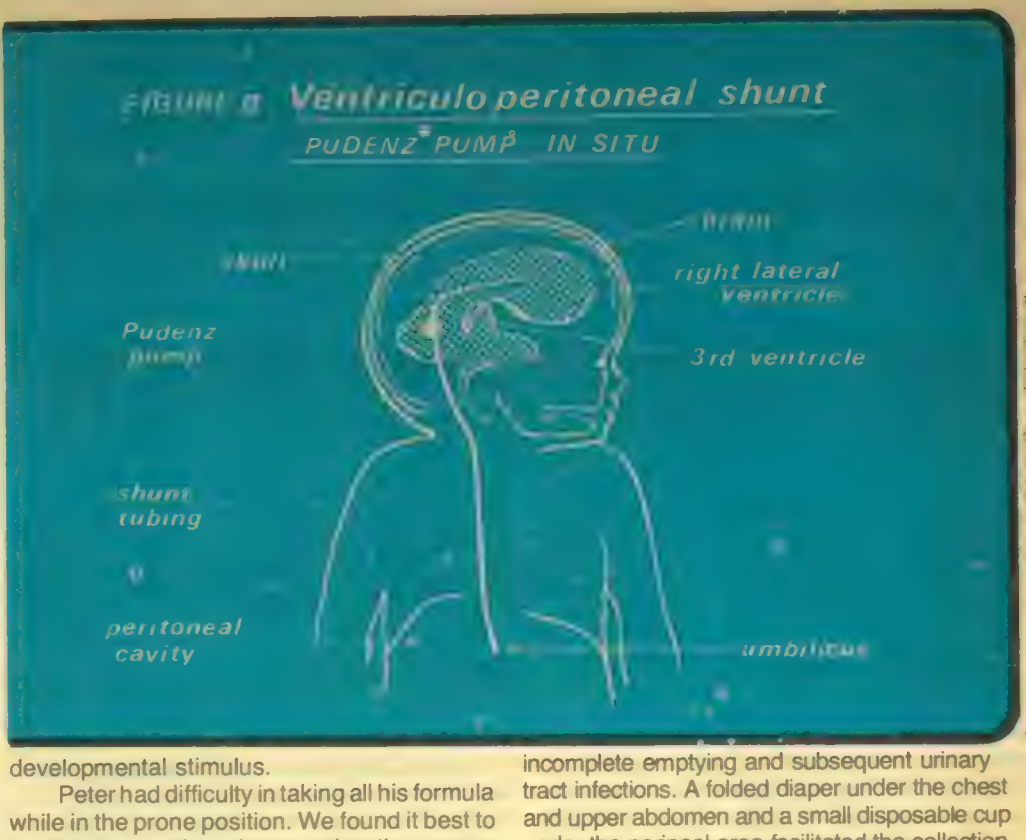
This defect results in motor and sensory deficits of various degrees depending upon its location and extent. In severe cases where the defect includes L2 and L3, there is flaccid paralysis and absence of sensation in the legs, together with complete incontinence of stool and urine. In others, where the defect is located below L5, the muscles of the feet and ankles may be affected and clubfoot or weakness of the anal musculature may occur. Among infants with myelomeningocele, there is a high incidence of hydrocephalus.

Usually, surgical treatment is done as soon as possible after birth to decrease the risk of infection and to facilitate the care of the infant. The prognosis for these children has improved considerably over the past ten years due to better neonatal surgical techniques.[3]

Illustrations courtesy of Shirley Mohyudden

above the eyebrows. There were no signs of increasing intracranial pressure until three weeks postoperatively, when the circumference of Peter's head increased from 35 to 39 cm. The fontanelles became full and bulging and the sagittal sutures were widely separated. Also at this time, he began vomiting small amounts after each feeding.

For the second time in three weeks, Peter had surgery. To control the developing hydrocephalus, a ventriculoperitoneal shunt with a Pudenz* pump was inserted (see Figure 2.)



*Registered trademark of Heyer-Schulte Corp. (Subsidiary of American Hospital Supply Corporation)

Nursing Care

One of the most important nursing observations on Peter's return to the ward was the assessment of his neurological status. He was observed carefully for signs of increasing intracranial pressure in order to detect a possible malfunction of the shunt.

Positioning Peter comfortably was a challenge. He appeared to be most comfortable in the prone position with his head to the left side and a folded diaper placed between his legs. This position prevented pressure on the myelomeningocele incision, controlled the flexion, adduction and subluxation of the hips, and prevented pressure on the skin over the Pudenz pump. Since Peter was unable to lift his head due to its increased weight, the nursing staff turned his head every two hours to the right side for 10-20 minutes to prevent stiffness of the sternocleidomastoid muscles.

The skin around the ear was massaged with cream each time his head was turned to prevent skin breakdown. Other areas such as the elbows, knees and feet were also massaged frequently to facilitate the circulation of nutrients and the removal of waste products by the bloodstream. To enhance this process and to prevent stiffness and contractures, the upper extremities were exercised through their full range of motion. Extending Peter's arms well above his head was especially helpful in preventing shoulder stiffness. Because of his lower limb paralysis, it was important that Peter's legs and feet be exercised gently. This was done with extreme caution since the bones of these infants tend to be fragile and rough handling can cause fractures.[6] Approximately 2-3° of flexion was achieved with passive exercise of the knees. Passive foot exercises included dorsiflexion, plantarflexion, eversion and inversion.

Since Peter could not yet be held or cuddled and his condition necessitated that he lie in a prone position, the nursing staff utilized every opportunity to provide him with sensory-motor stimulation and "people contact." Thus, exercise periods, for example, would be turned into a game where the nurse established eye-contact, and talked to and played with Peter. This provided some visual and auditory stimuli which otherwise were limited to those in his hospital room. Playing a radio or a wind-up music box provided variety in sound stimulation as did singing and talking to him. A bright red rattle suspended from the crib rail at eye level provided him with another developmental stimulus.

Peter had difficulty in taking all his formula while in the prone position. We found it best to feed him every three hours rather than every four hours and give him one ounce of formula less each time to increase his fluid and caloric intake. Placing my left hand under the infant's upper chest, neck and head helped to raise him sufficiently to facilitate feeding. Stroking his cheek and massaging the muscles used in sucking also helped to improve his swallowing. The use of a small-holed nipple prevented Peter from swallowing excessive amounts of air. After each ounce of formula, I stopped and gently rubbed Peter's back for a few minutes while keeping his head and chest slightly elevated.

As soon as the repaired myelomeningocele was well healed, Peter could be held during his feedings. This not only provided variety, stimulation and security for him, but was also conducive to improved integumentary and respiratory status.

Due to the level and extent of his defect, Peter had a neurogenic bowel and bladder. Sacral nerve involvement interrupted the reflexes essential for micturition and affected the levator ani and external anal sphincter musculature causing decreased tonicity of the anal sphincter.

Elimination of urine was facilitated by the Credé maneuver (application of suprapubic pressure over the bladder).[7] This was accomplished by standing at the foot of the crib and grasping the infant's hips with both hands so that the thumbs extended along the buttocks and pointed toward the infant's head. The bladder was compressed firmly between the first two fingers and the spine. Pressure was maintained until the flow of urine ceased. Although Peter voided spontaneously between bladder expressions, this procedure was repeated every two hours in order to prevent incomplete emptying and subsequent urinary tract infections. A folded diaper under the chest and upper abdomen and a small disposable cup under the perineal area facilitated the collection process. After each expression, the amount and characteristics of the urine were observed and recorded accurately and the perineal area was cleaned thoroughly.

With a neurogenic bowel, constipation can occur easily due to a lack of normal contractile tonus in the lower bowel and rectum. It was important that Peter not become constipated because it could result in compression of the peritoneal end of the ventriculoperitoneal shunt and eventually cause it to block. Therefore, the characteristics and amount of stool were carefully recorded.

Members of the health team including physiotherapist, social worker, public health nurse, and hospital nurses met as a group to plan for Peter's care and discharge. Realistic goals were established early in order to ensure that potential problems were not overlooked. For Peter, these goals were to:

- take 90 cc at each feeding
- have adequate daily output of urine and stool
- remain free of infection
- sit in a baby seat
- go home with his parents.

For Peter's parents, the agreed upon goals were to:

- feed Peter
- hold him
- bathe him
- express his bladder
- disempact his rectum
- exercise his extremities
- pump ventriculoperitoneal shunt if necessary
- know early signs of intracranial pressure
- know adequate inputs and outputs
- know appropriate stimulation for him
- feel confident in caring for him.

The public health nurse provided a liaison between the hospital and the home and helped to communicate these goals to the nurse in the community.

Peter's Family

Helping parents face and cope with the reality of a newborn child with a severe defect is a difficult task but one which is of utmost importance. Peter's parents had not anticipated the birth of an abnormal infant and they felt grief for the healthy baby they had expected and guilt that they might have done something wrong to cause the defect.[8,9] During the first week after Peter's birth, neither parent came to see him. His mother was still in hospital in the postpartum unit and his father was torn between visiting his wife or Peter who was in a different hospital. He decided to spend his time with his wife because she was upset and he thought she needed his support.

Seven days after their baby was born, they came together to visit Peter for the first time. Both parents were anxious and concerned about their baby's condition but expressed this in very different ways. Peter's mother tried to deny the severity of his condition and stressed to her husband how 'healthy' and 'happy' Peter looked. Although she had been told about Peter's paralysis, she "normalized" his immobility by saying, "He's such a good baby. He never squirms. He seems to be contented to lie in that position all the time." Peter's father was very quiet during his first few visits and looked away each time I approached him. Because his first language was Greek, he seemed to be unsure of his ability to share his concerns. An interpreter helped a great deal to clarify things for him and to make him feel more comfortable. One day, when talking to a physician he became very angry stating that his son's defect was all "the doctor's fault." This was the first time he had verbally expressed any of his feelings about Peter's condition.

Building up a relationship based on trust between the nurse and the parents was an essential beginning in helping them cope with their new situation. To accomplish this, I answered their questions honestly and gently, and demonstrated, by my frequent presence, my acceptance of them and their baby.

It was helpful to call Peter by name and to refer to "you and Peter" as a unit, when I talked with the parents. This simple intervention assisted them in linking themselves with their child in their planning for their future. By example, I encouraged them to touch Peter, to play with him, and to sing and talk to him. These "parenting" activities were difficult for them, however, because they were afraid of "harming" their baby. I tried to emphasize Peter's healthy behavior as much as possible, for example, taking all of his feeding; gradually, the parents were able to touch Peter while talking and playing with him. This behavior as well as the parents' questions about Peter's feeding patterns indicated that they were ready to learn some techniques about caring for their baby.

In my initial interviews with the family, I discovered that the parents' knowledge of baby care was limited. Both parents were the youngest in their families and neither had any experience holding, bathing or feeding an infant.

Our teaching-learning sessions were directed towards meeting the goals set by the health team, and began with informal demonstration-discussions of Peter's feeding behaviors, and moved the next day into supervised feeding periods initiated by the mother. Sympathetic and understanding teaching and positive feedback about successes assisted her in gaining confidence in her own mothering abilities.

The parents had many new skills to learn before they would be ready to care for Peter at home. These included how to hold and bathe Peter, how to detect early signs of intracranial pressure, express his bladder, disempact his rectum, determine adequate intake and output, exercise his extremities and position him appropriately.

Each learning need or problem was assessed by the nursing staff in a systematic manner by being alert to verbal and nonverbal cues from the parents and evaluating their developing knowledge base, skills and readiness to pursue the task. For example, I noticed that Peter's mother tightened her facial muscles while she was expressing Peter's bladder. When I asked her about this, she said that she felt tense and worried about the procedure. By placing my fingers over hers and pressing down on the bladder with her, she was able to judge the pressure required to empty the bladder and felt more confident about doing this task.

With practice, both parents gained skill in assessing Peter's problems and in performing the techniques necessary in his care. Before Peter's discharge, they felt they could carry out the basic daily tasks required. They will still have to adjust their usual daily activities to include this rigorous regimen without redirecting their goals completely when they take Peter home.

Concern for the Future

For this family there will be many future concerns and stressors. There are still many questions they may want answered (i.e. How can we provide Peter with appropriate stimulation as he develops? What type of schooling would be most appropriate for him? How can we help him find playmates?) The community nurse with the help of the public health nurse from the Society for Crippled Children can provide guidance to assist the parents to prepare for problems associated with Peter's development. At the present time there is no special equipment required for Peter's care. As he grows, he will probably require special carts for mobility, wheelchairs, braces, orthopedic shoes and urinary appliances. The public health nurse in collaboration with other members of the health team can assist the family to adapt to each new situation.

Peter will be further assessed in the combined spina bifida clinic at the Ontario Crippled Children's Centre. Then he will have ongoing assessments (i.e. urological, orthopedic, physical medicine and neurological) at three to six-month intervals as needed.

The family was also referred to the Spina Bifida Association which promotes the welfare of individuals with spina bifida and their families and provides support through a group approach to problem-solving.

Summary

Caring for a child with a myelomeningocele is not a task that one person can accomplish on his own. An interdisciplinary team approach, early parental involvement in the baby's care, a thorough knowledge of community resources, and parental understanding of the long range implications will greatly influence and affect Peter's early years. With support from both professionals and relatives and friends, it is hoped that they will develop a positive attitude to this challenge and continue to demonstrate their love and concern for Peter.



Judith M. Hendry (R.N., Hospital for Sick Children, Toronto; B.Sc.N., University of Toronto; M.Sc.N., University of Western Ontario) is presently a lecturer at the University of Toronto, Faculty of Nursing. She prepared this paper while working on a surgical infant area at the Hospital for Sick Children in Toronto.

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Sexuality and the disabled

Elizabeth Finch

In recent years much literature and discussion has centered on human sexuality. Society has pried into, questioned, evaluated and generally exposed to public view, many areas of human sexual needs and behavior that were once considered taboo. Ideally, this kind of scrutiny leads to increased knowledge about what it means to be fully "human."

For the handicapped person, the journey towards a better understanding of his/her sexual potential has been a little slower in getting started. Ignorance about the sexual feelings of the handicapped person has kept the subject shrouded in embarrassment and silence but attitudes are changing. Workshops and conferences being held in centers across Canada are one means of increasing communication among health care workers and the disabled. This ensures that better sex education and counselling is available as well as providing a means of improving public education and understanding of the disabled person and his needs.

An example of this type of conference was the one held some time ago at the Royal Ottawa Hospital and co-sponsored by Algonquin College in Ottawa and SIECCAN (Sex Information and Education Council of Canada). The three-day conference, entitled 'Sexuality and the Disabled,' brought together health care workers and physically disabled persons in a relaxed and accepting atmosphere to consider human sexuality in its broadest sense and to study the more particular difficulties experienced by the disabled in the expression of their sexuality.

The tone for this Ottawa workshop was set during the opening address by Beverley Thomas, Executive Director of Planned Parenthood British Columbia. Beverley is a quadriplegic who twenty years ago sustained a spinal cord injury as a result of a diving accident. With a mixture of gentle humor and candid self-disclosure, she opened the door to the forbidden area of sexuality and made it possible for those present to begin taking a long, hard look at their own values and beliefs, as well as the taboos, myths and misconceptions surrounding sexuality in general and sexual practice in particular. She told her audience:

I don't want to be the odd guy out. We're people and that's important. Because I have to wheel to get from here to there is nobody's business but mine. But we do have to pick up some people on the way who will share that experience with us — we have to find those people who will love us for ourselves, and not worry about those who can't ... in any experience where you are trying to create trust, you have to take risks.

By being together in both large and small groups, those at the workshop were able to exchange information, opinions and experiences with one another. For example, participants engaged in some value clarification strategies which allowed them to look in some depth at their own attitudes towards sexuality. In order to understand what this exercise involved, imagine yourself in a small group setting. You are given a small card on one side of which is written a general statement about sexuality. You are asked to respond to the statement. Then turning the card over, you are asked to respond to a more specific statement. You may elect to pass if you wish and no one may interrupt you until you finish. Suppose your first statement is:

Physically handicapped children should be given opportunities to develop their own sexual feelings realizing that they may not get these opportunities as other children do.

More than likely you are able to comment on the statement with a fair degree of ease. But, how about the reverse side?

Your 13-year-old niece tells you that a close girlfriend, who is unable to use her hands, has asked for assistance in masturbating because she wants to find out how it feels. She asks you if you think it would be OK."

This is not quite so easy. Although some participants thought the whole exercise too academic, it did permit those unaccustomed to speaking freely about sexual matters the freedom to do so in an atmosphere that was accepting and nonjudgmental. This attitude was an outstanding feature of the conference. No one felt pressured to talk about their own sexual experience if they did not wish to do so.

In group sessions, participants considered sexuality in its broadest sense, as well as examining the importance of establishing meaningful relationships — "How I view myself as a man or a woman?" —"How can I express my masculinity or femininity in ways acceptable to myself and my partner?"

One gentleman, who has multiple sclerosis and is confined to a wheelchair, shared the following:

My sexuality consists of more than my genitals. For many of us here, they don't work anymore. Touching and holding someone I care for is important to me. Why, I can have a spiritual orgasm just looking into my partner's eyes!

A woman participant recounted her determination to look just as attractive and feminine as any other woman:

By golly, when I went out to the Queen Elizabeth (theatre) and for dinner, I was going to wear a long dress just like anyone else, I was going to get there, I was going to wheel up to that table and I was going to ask the waiter to cut my meat.

This kind of sharing not only provided much needed encouragement to other disabled people but also helped to dispel the misconception that sexuality is synonymous with sexual intercourse. As McRae and Henderson state:

Sexuality has many modes of expression, ranging from the baking of an apple pie for a loved one to sharing one's body. Sexual behavior is a private affair between partners, having variable significance depending upon the psychologic, physical and social environment of the moment.[1]

A variety of discussion groups centered on the specific problems experienced by individuals with different physical disabilities or dysfunctions. Knowledge related to sexual activity for people with pain and joint stiffness, speech and communication disorders, spasticity, muscle weakness and immobility was shared by the participants who were encouraged to choose the group best suited to their needs. Resource people for each group included a leader having special knowledge of the particular disability and a facilitator to provide support and promote meaningful interaction between members.

A panel discussion, "Growing Up with a Disability and Learning to Live with a Disability," was presented by four disabled people who shared where they "were at" in terms of their own sexuality and how they got there. The courage and determination of these people who shared some of the most intimate and what, for most of us, would be devastating, experiences in their lives was greatly admired by the audience.

Conference Outcome

Effective workshops and conferences have a tendency to raise more questions than they answer and this one was no exception. The final sessions were devoted to formulating the questions and common concerns of the participants into meaningful recommendations. A total of 22 recommendations were accepted for circulation to provincial and federal government agencies, health care and residential agencies, and health education institutions within the Ottawa area. Participants agreed that:

- directors and supervisors of health and residential facilities should
— allow self-governing by the disabled persons in all non-medical matters,
— provide appropriate facilities, such as a furnished room with adequate privacy for personal use by residents on request.
- an ombudsman (priority to a disabled person) should be appointed to be the liaison between the associations of the disabled and the government (federal and provincial).
- all in-patients and out-patients should be given instructions about the effects of drugs on their sexuality.
- a sexual therapy team should be identified within all Rehabilitation units in Ontario.
- subsidized transportation should be made available to the disabled to allow for socialization.
- disabled children should be integrated with other children throughout the general school system.
- all educational programs for health care professionals (including inservice) should provide courses in sexuality, and sexuality and the disabled.
- institutions and places of care (i.e. active treatment hospitals, chronic hospitals and homes for the elderly) should allow individuals to express their right to privacy and support the individual's dignity in this expression.

To devise strategies for implementing these and other recommendations for change, a core group of thirty-five people from the workshop continue to meet and evaluate their progress. They anticipate that through public education and a better understanding of human sexuality the needs of the disabled in the expression of his sexuality will be met.

Nursing Implications

During the course of the conference, participants became increasingly aware of the significance of the observation by one of the workshop organizers that:

The fundamental issues relating to human sexuality encompass personal value systems, life-styles, self-image and communication mode as well as how people in relationships act toward each other.[2]

Acceptance of the idea that these words apply, not just to the patient — the other guy — but also to nurses themselves, carries with it several important implications among them:

- Our sexuality is not out there somewhere, it is an integral part of our total being. It is not just something we *do* privately. It is our confirmation of ourselves.
- Until we are comfortable with our own sexuality, we cannot help anyone else. Being comfortable for some may simply mean that when a patient broaches the subject of sexuality, you, his nurse, can honestly say, "I find it difficult to talk about intimate matters of this nature, but I know it is important to you and I will put you in touch with someone who can help you with this concern."
- We don't all have to be counsellors on sexuality but we do have a responsibility to our patients.

An individual who undergoes an alternation in body image is certainly going to have concerns regarding his sexuality. The nurse, in helping her patient through the rehabilitation process, can encourage the patient to take the initial risks required in trying out his "new image" as he relates to his friends and loved ones, and in making new acquaintances. Some individuals have to learn to love all over again.

This demands a lot of courage as well as a great deal of support from the health care worker most closely involved, the nurse. Therefore, we must become as knowledgeable and as comfortable as possible in this whole area if we are to be of help to the disabled person.

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Elizabeth Finch *(R.N., Toronto General Hospital; B.N., M.Sc.(Applied) McGill University) is the coordinator of nursing inservice education at the Royal Ottawa Hospital, Ottawa, Ontario.* *While attending the conference, "Sexuality and the Disabled," she was struck by the open and sincere sharing of feelings by the participants who earned "our undying respect, admiration, and gratefulness. Beverley Thomas, for example, who gave the opening address is without a doubt a remarkable, vibrantly alive woman."*

"It took an enormous amount of courage and 'sheer guts' for these people to share some of the most intimate and what for most of us would be devastating experiences in their lives."

To those nurses who feel embarrassed discussing the topic of sexuality, Finch adds, "When you are overcome by these feelings, look at your patient who knows more about embarrassment, fear and vulnerability than most of us could ever imagine."

Caring for the Patient

a supportive approach to individuals in conflict with society.

Jane Worden

Three years ago, when I moved to the Forensic Unit of the institution where I work, the only thing I knew for sure about the patients there was that, at some point in their lives, they had all come into conflict with the law and had been subject to judicial process. Since then, I have cared for many of these patients and come to appreciate some of the problems involved in their rehabilitation.

The need for nurses in this area of psychiatry is growing as the need for more facilities for the assessment and treatment of these patients becomes increasingly obvious in our society. It is my hope that this personal account of my experiences and observations will spark a corresponding interest among other nurses.

The Forensic Inpatient Unit of the Clarke Institute of Psychiatry in Toronto can handle a maximum of 22 patients — 19 male patients, three females. Since most of these patients are remanded to our custody, the doors of the unit must be kept locked. The unit provides both assessment and treatment. Assessment is at the request of the courts, on behalf of the defence attorney, crown attorney or judge. Most patients are remanded for from 30 - 60 days but staff may request an extension or ask to have the patient returned to custody before the designated time is up.

Assessments may be pre-trial — i.e. the person has been charged with an offence but not yet tried, or pre-sentence— i.e. the person has been convicted of an offence and an assessment requested, usually to aid the judge in dispensing an appropriate sentence to a suitable institution.

Assessment

Thirty to 60 days is obviously not a very long time in which to do a thorough assessment and therefore the staff must work quickly to discover all the relevant information. Along with routine blood and urine tests, an E.E.G. is usually done to rule out brain dysfunction that could have some bearing on the person committing the offence with which he is charged. Extensive psychological testing is carried out and detailed histories are taken by the doctor and added to information gathered by other staff involved with the patient.

Staff-patient contact varies from person to person and ranges from group therapy to one-to-one interactions with staff, but evaluation of the day-to-day social dealings with co-patients is probably our best tool for assessment. We see examples of many psychiatric illnesses, but most patients are labelled as having "personality" or "character" disorders. In textbook terms, they are individuals whose behavior is amoral and anti-social, whose actions are impulsive, irresponsible, and serve immediate interest with little or no feeling of guilt or anxiety and without concerns for the legal or social consequences of their act.

Each written report submitted to the court on the completion of an assessment is compiled by the doctors from information gathered by team members, including the nurses, social workers, psychologists, occupational therapists, and the doctor himself. The report contains information such as whether the person is fit to stand trial, based on whether he is certifiable under the Mental Health Act 1967, whether he understands the nature of the charges and the possible implications and consequences, whether at that point in time he is able to follow court proceedings and advise his lawyer.

appropriately, and whether he understands the meaning of the oath to be taken in court. A more personal assessment of the patient's personality is also outlined and recommendations are made for treatment, either in a psychiatric facility or in an appropriate institution in the penal system.

Treatment

Along with assessments, the unit accepts some patients for psychiatric treatment. Re-admission of former patients for "crisis intervention" is not uncommon. Sometimes the court recommends that one of our patients who has had an assessment be returned for treatment instead of incarceration. There is another group of patients who after serving some part of their sentence may be returned to the unit on a parole basis — i.e., by serving the remainder of a sentence in close contact with an agency that provides rehabilitation to the community. Our rehabilitation program has extended to include patients now considered "sane" and released from the Hospital for the Criminally Insane in Penetangueshene, Ontario as ready to re-enter society.

On the Job

My nursing experience on the forensic unit began when I requested a transfer after several openings became available. The idea of working with "criminals" was intriguing and it was probably this curiosity that led me to apply.

The first two weeks went by as if in a dream. I recall sitting in the nurses' station reading charts and trying to fit the "charges" with the faces that occasionally appeared. That was, and still is, an impossible feat.

I learned very quickly that each of these patients is an individual. Initially, most struck me as "nice guys," it was difficult for me to connect an individual with, for instance, a brutal rape, an armed robbery, or even murder. This tendency to stereotype and prejudge is one that I had to overcome; as very often it caused me to be less than objective in my approach to these patients. I came to the conclusion that I was doing myself and my patients an injustice. I soon realized that each patient has district needs peculiar only to him. The team approach helps to maintain this objectivity by a system of effective communication between members and by providing necessary feedback and even conflicting opinions.

As we get to know our patients, problem areas begin to surface. Our unit is often their last contact with "society" before a long period of incarceration. Sometimes a patient is making a last attempt to get help after years, often a lifetime, of problems. For many patients, it is too late. They must face the legal consequences of their deeds, and their chances for rehabilitation in the prison system are slim. Often, patients have agreed to this assessment period merely to get a "good report," in the hope that the judge will allow them to go free on bail or to receive probation, a shorter sentence or even acquittal. They believe that if they are "good" and attend all the activities available they will receive a favorable report. They soon learn that this is not the case.

After the staff has prepared the groundwork, the patient can either start working in groups and on a one-to-one basis with his staff, including at least two primary nurses, or he can sit back and openly admit to little or no motivation. We try to get the patient to make this decision himself but this is not easy for a person who has always avoided accepting responsibility for his actions.

The therapeutic milieu we try to attain on our unit is based on trust ... a small word with enormous connotations. Some of these patients have never trusted anyone, much less a stranger, in the form of a nurse (who is after all, an authority figure). As staff, we are constantly tested with statements like — "You don't really care about me. This is just your job." We try to respond in an honest, straightforward and consistent manner. Openness and honesty on the patient's part are also stressed. Using a give-and-take approach, sharing a little of ourselves and expecting the same in return, we try to establish a therapeutic relationship with each patient.

I share my expectations with him in the hope that he will begin to take the responsibility upon himself to set some realistic goals, and understand his personal limitations. Often he needs a great deal of guidance and support in these areas, but the nurse-patient relationship can be such that he will accept these from her.

In working with the forensic-type patient, it is important to refrain from setting goals that are beyond his reach or imposing rigid, middle-class values . Instead, I try to set what I would consider easy goals so that positive gains are achieved and recognized by the patient relatively quickly, thereby helping him to acquire the self-confidence he so desperately needs.

We must carefully examine the socio-economic background of each candidate for rehabilitation and then also consider how much of his life has been spent in institutions. We must be careful not to automatically assume that he can function in our society. Realizing this, I try to be sensitive to the needs of a patient to learn what I would consider an elementary task, like using a telephone or operating a vending machine. try to make the patient aware of this understanding early in our relationship.

Good rapport, mutual understanding and trust make it possible for the patient to be less threatened in admitting his need to be taught and protect his pride and self-esteem from further damage. This supportive, non-threatening approach to teaching simple life-skills can be expanded into more complicated areas like interpersonal and social relationships. It is a slow and difficult process, but often it can lead to the roots of serious problems of depression, alcoholism or inadequacy that may, in turn, result in difficulties with the law.

At first, I found it difficult to understand the unconscious desire of some patients to return to jail. Usually these people have a history of repeated institutional admissions, ranging from orphanages to maximum security institutions. They have come to believe that prison will accept them and provide the security they so desperately need when society will not. In many cases, this is a fact. It is not unusual, for instance, to see one of our patients receive probation after assessment and return to us for rehabilitation. He begins to learn how to live a decent life, he finds a job and a place to live. He is discharged and seen on a regular out-patient basis. Then, suddenly, he is up on another charge, for no apparent reason. More often than not, he is just not ready to cope with the everyday hassles of life, and the institutional environment offers him a secure alternative to coping. Douglas was a patient like this ...

Case History

Name: **Douglas H.**
Age: **25**
Birthplace: **Smalltown, Manitoba**
Present Charge: **Break and Enter, Two Counts.**

This patient was admitted for a 60 day assessment at the request of the trial judge prior to sentencing. Over the past ten years, he had been in jail many times on various charges. Invariably, he was under the influence of alcohol when he committed his offences. Previous psychiatric contact was nil. Familial history revealed an alcoholic father and a mother who died when he was four years old. Doug spent four years in various homes in the community and then was adopted by a paternal uncle and his wife. While he was well provided for physically, his emotional needs were not adequately met, especially after the birth of a stepsister.

Doug's real father introduced him to alcohol use when he was 12 years old. It would appear that in these formative years, he was confused and torn between identifying with his real father and his stepfather, as his adult model. He was still in close contact with his father and two brothers in the small community where they lived and alcohol was his way of relating to his "real family."

Doug was a shy, introverted teenager who used alcohol for courage and confidence in social situations. By 16, his dependency was uncontrollable and he needed money to support it. His first conviction was at age 15 and for the next ten years he progressed from county jails to the federal penitentiary, with only brief periods out on the street. While in prison he relates a considerable use of alcohol in the form of illegal "moonshine" made by the inmates, so his dependence was never really interrupted through incarceration.

Assessment

When Doug arrived on our unit, he presented as a suspicious and quiet individual, unsure of the reasons for his admission and mistrustful of staff and patients alike. With a long history of incarceration this is not an unusual response: as nurses, we are confronted repeatedly with patients who question our motives in trying to establish a relationship. The self-esteem of these patients is often so low that they see no reason for our concern.

Since Doug seemed unable to trust anyone, consistency of staff and a non-threatening approach were very important. He was encouraged to become involved in all the groups available including a closed insight-oriented group. Psychological testing revealed little pathology other than a tendency toward hypomania and impulsivity. A series of EEG's revealed some permanent organic dysfunction due to chronic use of alcohol. Nevertheless, he showed many resources, intellectual and emotional, that he could use if motivated to do so. The prognosis remained guarded due to his long history of alcoholism. Doug himself admitted to a problem in this area though and expressed a desire for help with his problem.

During his 60 days on the unit, Doug proved to be a warm, caring individual, with a capacity for insight, and the ability to form interpersonal relationships with staff and patients. Team members felt that treatment could result in his eventual rehabilitation back into the community and recommended probation. The judge concurred and Doug received a sentence of two years probation.

Doug felt his drinking problem was the result of his background and it would appear that alcoholism was a symptom of early deprivation, identity confusion, low self-esteem and contact with a lifestyle condoning extensive use of alcohol, typical of the community where he grew up. His self-esteem improved remarkably as the result of feedback from patients and staff about the positive aspects of his personality. His general popularity on the ward resulted in his serving on patient committees and he became an appreciated as well as productive group member. The peer group support he received was important but the genuine caring that the staff demonstrated was probably more important because we were role models for him. Doug's motivation to change was very high.

Treatment

After sentencing, he was supposed to continue in group and individual therapy for approximately two months to facilitate further growth and improve his self confidence so that he could seek employment and live in the community.

Treatment for Doug's alcoholism was discouraging. It was important that he transfer his dependency on alcohol to a healthy dependency on the unit, especially after discharge when he would need a great deal of support but this was not easy since he regarded any dependency, especially on women, as a weakness. Doug knew that continued alcohol abuse would mean more brain damage and possible return to prison. Intellectually he was able to say that he had to stop drinking. Emotionally, he had to discover for himself whether he could control his drinking rather than stop. On his first pass , he returned to the unit quite drunk. In this condition, he was angry, verbally abusive, aggressive and objectionable. His memory of this behavior was almost nil and when confronted with it, he was frightened enough to agree to begin treatment with Antabuse. This continued for about a month but he regarded this medication as a crutch and preferred to be independent. Since regaining his self-respect was extremely important to him the staff did not force the issue.

Release

Eventually, Doug returned to the community. Through employment counseling and much searching on his own, he found a good job and was well-liked by his fellow employees. Out-patient follow-up, in the form of supportive psychotherapy with two of the nurses who were his primary staff, was continued on a weekly basis for three months. Then, he was charged with assault following a drinking incident in a tavern. Because the charge involved a breach of probation, the judge sentenced him to the penitentiary.

Should we regard Doug's treatment as a failure? Where did we go wrong? Did we waste a lot time and energy on a hopeless case? I would have to answer "NO" to all of these questions. I feel that Doug benefited immensely from our program. I think that loneliness and situational depression, leading to an increasing use of alcohol again after discharge were the cause of his "downfall." He admitted that drinking was his only way to socialize. Apparently his ability to be independent was limited and I feel this was due more to his long history of institutionalization than to any failure on our part.

Although Doug ended up back in prison, I feel sure he will maintain the gains he made and be able to use these once he is released again. He definitely learned a great deal by his mistakes and he was certainly aware that he had to take responsibility for his own actions. As nurses, we cannot feel responsible for this so-called failure and, as a team, we can use cases like Doug's and countless others to learn from and discover new and different ways of dealing with future patients.

Summary

Invariably, we spend many, many hours working with "antisocial behavior" problem patients before we see even a small amount of progress. I try to maintain a degree of perspective with each individual patient. I have learned to cope with temporary defeat and discouragement. Eventually, a substantial number of our patients do make it. There may be crisis-intervention admissions or another prison term intervening, but often this is just part of the learning process. What seems like a tiny step forward to us, is often really a giant step for the patient and the trial and error process really does work in the long run.

At first, many of our patients appear to be beyond our help. I am amazed, however, when I think of the number of them that we have almost given up on who suddenly do a complete about-face and begin to work themselves on their problems.

In this job, I am constantly learning new techniques, new theories, new approaches. I have made some mistakes but I have also learned to periodically reassess my old values and adapt some of them to meet the needs of the patients and the unit. In short, my work with forensic patients has been a rewarding experience; through it, I have achieved personal growth beyond my original expectations.



Jane Worden, R.N., author of Caring for the Forensic Patient, worked on the Forensic Unit of the Clarke Institute of Psychiatry in Toronto for almost four years before writing this article. She points out that her observations are based entirely on personal opinions and her experience on the Unit, developed in consultation with co-workers. A graduate of Peterborough Hospital School of Nursing, Peterborough, Ontario, Worden joined the staff of the Clarke Institute in 1971. After 15 months on the Child and Adolescent Unit, she transferred to the Forensic Unit where she remained until recently.

She is now working as a home care worker with the East Metro Children and Youth Services Department of the City of Toronto. In this position she says she deals with "potentially forensic-type patients," treating the entire family along with the child.

The Nurse Continuum Perspective



This article is unique in the fact that it is not based on past studies; it does not include statistics or references, nor does it have a bibliography. It is, quite simply, a description of one nurse's ideas about the interaction between members of the nursing profession at this particular point in time.

Author's preface:

This personal expression of attitudes and opinion is not meant in any way to indicate issues of nursing education, nor to reflect on the quality of nursing care in any specific area. During the 26 years that I have been involved, either directly or indirectly, with nurses, many of my friends and associates in both Canada and the United States have voiced their concern over the status of nursing. This article is the result of their comments, as well as my own personal experiences in the area of nurse-nurse relationships.

I note, also, the contribution of Dr. W.B.W. Martin, Department of Sociology, University of New Brunswick. Dr. Martin, who is the author of The Negotiated Order of the School (MacMillan Company of Canada Limited 1976) delivered the series of lectures on small groups that helped to pinpoint the interpretation of nurse-nurse associations described below.

Hopefully, readers of The Canadian Nurse will recognize that this perspective is not stereotyping, for the notion of a continuum suggests that there is constant opportunity for change. It is never too late to alter our behavior patterns. That is the whole meaning behind the Nurse Continuum Perspective.

It is the author's contention that it is not systems, governments or other disciplines that are the greatest barriers to the progress of nurses in the field of health care. The initial and most common barriers are, in fact, other nurses. Negative nurse-nurse interactions can be, and often are, a definite deterrent to change. Until this fact is accepted and dealt with appropriately nurses may continue forever on a weary continuum of stress.

Listening, sharing, encouraging and understanding are too often missing from nurse-nurse relationships.

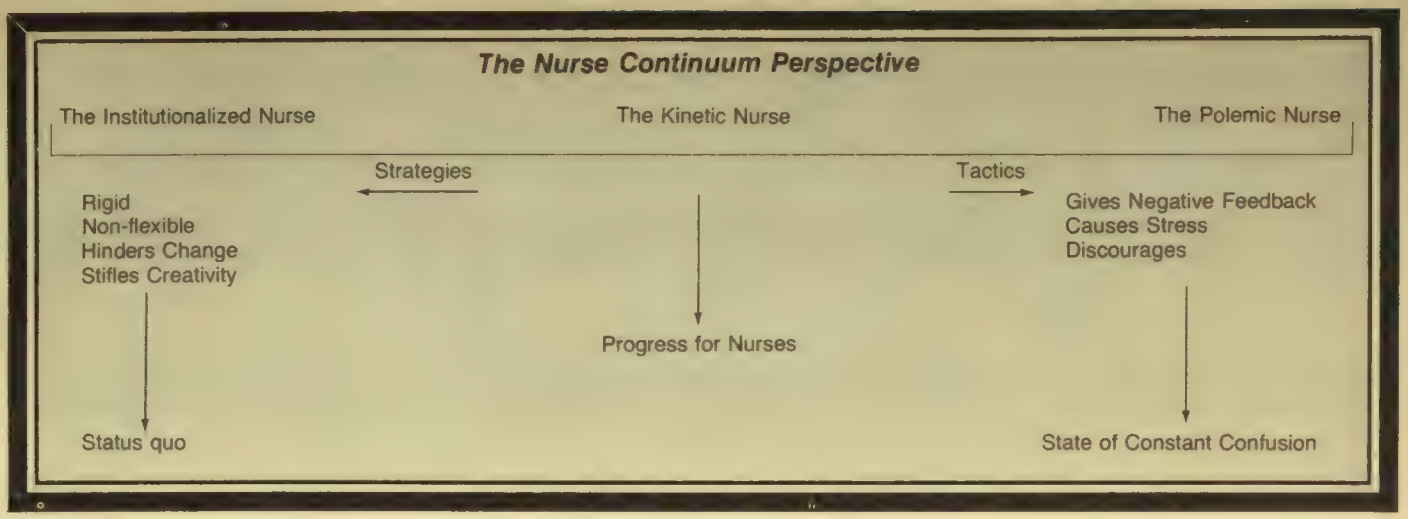
We can accept the fact that nurses are persons who should care about other people. What we cannot seem to accept is the fact that nurses should also specifically care about other nurses. In our rush to reach a desired personal or professional level — in the constant struggle to cope with nursing problems — we frequently overlook the importance of the human qualities that are vital to the survival of good working relationships. Listening, sharing, encouraging and understanding are too often missing from nurse-nurse relationships. This failure to find a common ground and establish lines of communication stifles and inhibits efforts to negotiate and compromise. In the end, talks break down, impetus is lost and change becomes impossible.

In an attempt to open the lines of communication between nurses and to create greater understanding, the author has devised a simple but dynamic tool that offers some handy landmarks in recognizing the difficulties inherent in nurse-nurse relationships. The Nurse Continuum Perspective proposes three broad groupings of attitudes with varying degrees of compliance measured along a sliding scale between the two extremes. At one end of this continuum is the "Institutionalized Nurse" — who gives every indication of being a rigid, non-flexible, immovable object. Her position in the health care field seems relatively stable largely because, although she is verbally active, in actuality she strongly resists change. The contribution to nursing that the Institutionalized Nurse is capable of making is limited and almost never fully realized. She feels secure and comfortable only with well-established habits and routines; change represents a threat. In reacting to new situations, she often attempts to inflict her present notions and unchanging values upon other nurses.

The Institutionalized Nurse feels secure and comfortable only with well-established habits and routines.

Examples of the Institutionalized Nurse are familiar to all of us. A classic one is the nurse who stifles the creativity of other nurses with her deference to authority or constant compulsion to rigidly adhere to unimaginative procedure and maintain the status quo.

At the other end of the continuum is the "Polemic Nurse" who has rejected the bureaucratic system and constantly creates turmoil and stress by means of negative feedback. She seems incapable of making



constructive criticism and is noted for being picky over trivia — particularly while others are attempting to concentrate on the real issues of patient care. The Polemic Nurse presents a hazard to those around her because of the discouragement she causes among her associates. Polemic Nurses smother enthusiasm with their negative and hostile attitude and, unfortunately, co-workers who are exposed to this are inclined to give up in despair.

The Polemic Nurse subjects her co-workers to an unending stream of carping criticism directed against "the system" or the people she works with.

It seems strange that an occupational group that utilizes the concept of rewards to shape behavior, somehow overlooks the use of positive reinforcement in the patterning of behavior in other nurses. (After all, other people besides Brownies like Brownie points!) Negative feedback discourages and depresses its recipients and both Institutionalized and Polemic Nurses seem to display a definite skill in this area.

Somewhere in the center of the Continuum is the Kinetic Nurse. She is the individual who continually tries to handle day-to-day situations in a creative and growth-producing manner; ultimately she is responsible for most of the improvements and advancements within her profession. Kinetic Nurses are pulled back and forth on the Continuum according to the frequency of their encounters and involvement with their Institutionalized and Polemic colleagues. This back and forth movement depends upon how skilled the Kinetic Nurse is in devising strategies and tactics for coping with these other two kinds of nurses. The maneuvers she is forced into often cause loss of valuable 'emotional' time and may cause the Kinetic Nurse to adopt some of the negative characteristics of the other two groups.

Periodically, many nurses feel compelled to "play the game" in order to obtain professional advancement or even survive. Kinetic student nurses may be confronted by an Institutionalized instructor. They recognize the passive role they may have to adopt to receive a favorable evaluation and they suppress their creative techniques accordingly.

"Playing the game" may also occur in other work situations. The Kinetic Nurse often finds it necessary to strive for approval of the Institutionalized and/or Polemic Nurse but, at the same time, has difficulty in maintaining the acceptance of her nursing peers. There is constant dissonance in this type of working situation and little opportunity for progress.

Both Institutionalized and Polemic Nurses, if they obtain supervisory positions, are often guilty of inhibiting Kinetic Nurses from expressing their true feelings. When this occurs, the profession is prevented from establishing better understanding among its members and with other disciplines. All nurses must feel free to share their honest concerns within their own professional group.

The "I Win - You Lose" attitude of many nurses defeats progress within the profession.

As a result of the polarizing effect of the Nurse Continuum Perspective, all three groups of nurses tend to adopt an "I win — you lose" attitude towards their fellow workers. In this kind of nurse-nurse relationship there can be no opportunity for compromise. Nursing issues remain unchanged and problems remain unsolved. Nurses cannot afford to be static; they must be dynamic and since Institutionalized and Polemic Nurses encourage stagnation and apathy, progress depends on the efforts of the Kinetic Nurse.

Readers will recognize that one inadequacy of the Nurse Continuum Perspective is the emphasis it places on the negative aspects of nurse-nurse interactions. Positive aspects do exist: how else could nursing have moved forward to its present position in the field of health care?

The Nurse Continuum Perspective is meant to present more than a philosophic viewpoint; it also has a pragmatic value. It applies to all nurse-nurse interaction and all areas of nursing. It gives each of us the chance to honestly rate our own position on the scale and, eventually, to assess one another's faults and merits in an objective and constructive fashion.

Nurses at all levels must develop the capacity to understand each other; they must make a concerted effort to work things out through compromise. They must encourage and support one another. A great deal remains to be accomplished in nursing but none of this will be realized if we fragment our resources and dilute our strengths.

"All things must change and we must change with them." If Kinetic Nurses can confront and negotiate with the initial barriers, (Polemic and Institutionalized Nurses) and at the same time succeed in obtaining the cooperation of these nurses in working together for the common good, then ideas can be shared and individual efforts encouraged. With these kinds of nurse-nurse relationships, progress in nursing will be measured in leaps and bounds.

Arlee D. McGee, *R.N., B.N., describes the Nurse Continuum Perspective, as "simply a means of providing food for thought in this area." She observes that, although a great deal has been written and talked about concerning nurse-patient interaction and also the doctor-nurse game, articles about nurse-nurse relationships are conspicuous by their rarity— even though this is a very significant area.*

McGee recently completed her post basic nursing degree at University of New Brunswick School of Nursing in Fredericton after an absence from the classroom that lasted over two decades. She is a graduate of Victoria Public Hospital School of Nursing in Fredericton and received a diploma in psychiatric nursing from the University of Western Ontario in London.

She was instrumental some time ago in starting a Home Visiting Teaching Program for developmentally handicapped children in York County, N.B., and this year she designed and taught a course for attendants working in alcoholism detoxification centers.

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■ **Bonnie Easterbrook** *(R.N.) is a graduate of the Toronto General Hospital School of Nursing in Toronto. She has worked as a counsellor with Planned Parenthood in Toronto and San Francisco, and was a team leader for a Community Outreach project through Planned Parenthood of Toronto in 1972. In 1973, Easterbrook helped to organize a teen conference 'Sex Seminar A to Z' for Planned Parenthood of Toronto. In 1974 she was an R.N.A.O. delegate to the Ontario Conference sponsored by the Family Planning Division of Health and Welfare Canada.*

■ **Beth Rust,** *(R.N.), the author's co-worker on the counselling team, is a graduate of Wellesley School of Nursing, Toronto. She is a past board-member and volunteer counsellor for A.C.C.R.A., and Planned Parenthood of Toronto and has had 5 years training and experience in family-life counselling with the Toronto Institute of Human Relations. Rust was also a participant in a summer program at the Institute for Sex Research at the University of Indiana.*

For the past two and a half years, nurses at the Toronto General Hospital have been involved in the education and counselling of therapeutic abortion patients within the gynecological/obstetrical service. It really began in 1972, when Nancy Snelgrove, a staff nurse in gynecology at T.G.H., recognized the need for counselling and support of therapeutic abortion patients. Up until that time, very little contraceptive counselling had been offered to them.

With the support of the nursing department at T.G.H., Nancy Snelgrove developed a program that involved visiting all abortion patients pre- and post-operatively. During these visits, she spent time discussing contraception with patients according to their needs, dividing her eight-hour shift between a regular patient assignment and the counselling of abortion patients. Gradually, she expanded her counselling role, and became the nurse-counsellor for all women admitted for therapeutic abortions.

We have been subjected to intense, rigidly defined sex-roles and unrealistic expectations for both men and women. Our attitudes are a culmination of many years of covert and overt sexual conditioning.

Two registered nurses now share in the counselling of patients admitted to T.G.H. for therapeutic abortions. Beth and myself both work in this capacity for four hours a day, an arrangement found beneficial to us because of the intensity inherent in abortion counselling, because of the necessary repetition of basic information, and because of the importance of a fresh and enthusiastic approach to individual patient's problems and anxieties each day. We work individually, although we have close contact with each other in our work.

Beth and I visit all women admitted to T.G.H. on an in-patient basis for either suction D & C or second trimester saline injection. Most women prefer to have a D & C under general anesthesia, while a small number have the procedure done in the out-patient unit with the help of a local anesthetic. (The out-patient unit is separate from our ward.) The doctor determines which procedure is most suitable for the patient.

Our initial visit with the patient occurs on her admission to the nursing unit. At this time, we explain how the abortion will be done. We encourage the patient to express her fears so that we can help to clear up any mistaken ideas she may have about the procedure. We also invite questions from the patient and her partner or parents.

It is our experience that most patients have not been informed about what is going to

happen to them, particularly if they have been referred to our service by a private physician.

We live in a society that sexualizes everything from shoelaces to toothpaste. On the one hand, it is a society whose media urge women to be sexy; paradoxically, it is a society that doesn't accept sexuality as a normal healthy part of whole human beings. Our sexual conditioning is, to say the least, confusing.

Their apprehension about the abortion itself is often compounded by the fact that they feel little regard has been paid to their emotional state at a time of intense personal crisis. During this visit, Beth and I attempt to find out if the woman has any support from her family, husband or boyfriend, so that we can help her to work out her feelings about their reactions to her decision. Quite often the fact of an unwanted pregnancy, or the decision to have an abortion forces the patient to question her perceptions of the relationship she has had with her partner. She may find herself alone at a time when most in need of acceptance and comfort.

Women are asking for good alternatives to the birth control pill for contraceptive purposes. The pill cannot cover the span of a woman's reproductive years. The combination of birth control foam and the condom is one extremely effective method for preventing pregnancy but requires the man's cooperation as well.

In preparing the patient for the procedure involved in the abortion, we tell her about the use of the laminaria tent. This device is used at T.G.H. to cause slow dilation of the cervical os in order to minimize cervical tissue tear and shorten the time necessary for general anesthesia in the operating room. The laminaria tent is inserted by a doctor on the evening before the abortion to begin dilation of the cervix. Occasionally, menstrual-like cramps occur. The tent is made of compressed seaweed, and resembles a small stick when it is inserted in the cervix. It is removed prior to the suction D & C.

Often when procedures and the rationale behind them are explained fully, the patient can relax within the hospital setting with less of the 'unknown' to fear. This may be the first time the patient has any feeling of acceptance and support for her decision. When the patient's or couple's questions have been answered, we tell her that we will see her after the abortion and on the morning of her discharge from the hospital.

Patients admitted for suction D & C come into the hospital on the afternoon or evening prior to the abortion. They have the abortion on the following day, and are not discharged until the morning of the third day, when we have a group discussion.

Our group meeting entails the discussion of after-care instructions, birth control methods, self-examination and the dynamics of male-female relationships. Prior to the group meeting our emphasis is on supporting the patient and establishing a trusting relationship with her. We consider this to be of importance because women admitted for abortions are often defensive and suspicious when they reach the hospital door — far too often they have been subjected to the dogmatic posturings of doctors, clergy and friends regarding their decision to have an abortion.

The onus has always been on women to assume responsibility for birth control. But women must not be confused about their sexuality; they must understand enough about themselves to be able to assert themselves and demand responsibility from their male partners.

Beth and I are also involved in counselling women admitted for second trimester abortions by intra-amniotic saline injection. This method is used for women who are at least 17 weeks pregnant, and requires that the patient remain in hospital for four to five days. As the patient having a saline injection is in the hospital for a longer period of time, we have more time to help her to work out her feelings about her decision. And this extra time is often beneficial.

Many of the women admitted for a second trimester abortion have had great difficulty in reaching a decision about what to do. The reason that a woman's actions are delayed may often be attributed to the fact that she has weighed her decision with painstaking care to

We hear so much adverse publicity about the pill, and hesitate to use it. It is difficult to feel secure when five doctors give five different answers to our questions about side effects.

choose the best of alternatives available to her. Some women have abortions at this stage of their pregnancy due to delays and misassessment by the doctor. Most of the



Author Bonnie Easterbrook (standing) and her co-worker, Beth Rust in their office at the Toronto General Hospital.

patients admitted for second trimester saline injections have in fact sought medical help immediately after they missed their second period. The patient may feel hostile towards her partner and/or men in general, a situation aggravated if her partner has abandoned her.

Beth and I wear street clothes during our working hours, a fact that helps many women feel more comfortable in talking to us. Very few women refuse to participate in our group discussions. There are however, exceptions. Often an older woman will prefer a one-to-one discussion with Beth or myself, feeling very strongly that she 'should have known better.' Other women may feel intimidated by groups — the patient and partner may feel much freer to discuss contraception when they are alone with us. Our program is flexible enough for improvisation and in such circumstances, we talk together in the privacy of the patient's room.

Most patients are pleasantly surprised by the group support that evolves during the meeting. Our patients are usually between the ages of 17 and 26, of varied ethnic backgrounds and religious persuasions. The group decides what direction their discussion will take while Beth and I act as resource persons. In the meetings, we discuss a whole gamut of topics related to women's health issues. We cover simple female anatomy and physiology, after-care instructions to follow the abortion, birth control methods and their efficacy rates.

After-Care Instructions for Patients Having Therapeutic Abortions*

1. Bleeding similar to menstruation will continue for seven days or less; watch if this bleeding is heavier and followed by severe cramps, backache and nausea.

2. Take your temperature for five to seven days, and if it is elevated for 24-48 hours and associated with the above symptoms, contact your family physician or come to the Emergency Department.

- *Do not take tub baths until bleeding stops; showers and sponge baths are permitted. Do not douche or go swimming until bleeding stops.*
- *Do not use tampons until your next period — use sanitary pads.*
- *Do not have intercourse until you have stopped bleeding — preferably wait until you have had one normal period.*

3. Strenuous exercise should be avoided for at least one week as it may cause further bleeding.

4. If your doctor has prescribed medication to prevent bleeding expect a few cramps and clots.

5. Due to hormonal changes, some women will experience depression or their breasts may be sore and perhaps leak. Wear a supporting bra and reduce fluid intake. Most important, realize it is a normal response and it will pass.

6. If you are going to take birth control pills, please begin taking them the first day you get home, according to directions in the instruction booklet.

7. In about one month's time, return to your doctor or to our clinic for a checkup.

8. If you have any problems within the next few weeks and want to talk them over, please phone us. (11:00 a.m. is a good time for phoning). Leave a message if you cannot contact us and we will call back.

*Specific to Toronto General Hospital, Toronto, Ontario.



Part of our discussion deals with female sexuality — our goal here is to demystify the topic and help women to feel comfortable with themselves and their bodies. This discussion continually reveals to Beth and I just how frightened women are to be open and accepting of their bodies. We deal with the topic in a frank and open manner — we talk about self-examination of the genitals, the vagina, the clitoris and its responsivity. Often this discussion represents the first time approval and encouragement has been given to self-examination. We emphasize the importance of honest, gutsy communication between couples regarding sexual feelings, and the responsibility of both partners for birth control. In this couple of hours, we hope to stimulate an expression of opinions and questions, and the beginnings of awareness.

The groups themselves provide positive feedback to our efforts — patients often relate their appreciation of our counselling and support to their doctors, who in turn tell us about it.

Beth and I make every effort to talk to interns and residents on the gyn/obs service about our counselling program to help create some awareness and understanding of the problems women confront when they have an abortion. We also contribute to the staff development program for our own gyn/obs departmental staff nurses.

We are entitled to learn and discover our sexual selves throughout our lifetimes. Our sexuality must be given positive value by our society.

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Boston Women's Health Book Collective *Our bodies, ourselves*. Rev. 2ed. New York, Simon & Schuster, 1976.

Recommended reading: Watters, Wendell W. *Compulsory parenthood: the truth about abortion*, Toronto, McClelland & Stewart, 1976.

Keeping up-to-date with new techniques and new ideas in her profession requires that the nurse continue to learn long after she has left school. Staff development programs provide an opportunity to do this in a structured, formal way within the hospital setting. But formal learning programs can be made more effective by using some of the techniques that adults use to learn on their own every day.

The Tip of the Iceberg:

Staff development and the universe of adult education

Jackie Barber

One of the thorniest problems confronting staff and administrators at individual hospitals today is the issue of inservice education. How much? how? for whom? are questions that administrators face in organizing staff development programs, and they may feel their problems are compounded by the ambivalent reactions they get from nurses. Many staff nurses feel that their professionalism is dependent on keeping up with advances in medical technology, learning new techniques and expanding their awareness, and are eager to participate in any learning experiences that are available. Other nurses seem to be completely uninterested in going to any more classes once they have finished school. The attitudes of head nurses toward staff development, whether they are willing to make work schedules flexible enough to encourage participation and what provision they make for nurses to use and share new knowledge with others, also determine the success of inservice education programs.

Hospital educators are faced with these and many other considerations in their attempts to plan successful education programs. To make the learning experience more valuable to individual nurses that participate, and thus to the hospital that gives them, it is helpful to look at some general principles of adult education.

The Magnitude of Adult Education

When adults learn, they do so in a variety of formal and informal ways. Formal education takes place in a classroom, lecture hall or conference room. It is directed by a teacher, lecturer, group leader or resource person. Formal education can be quantified. You can count the number of people who attend class, the number of hours spent in the classroom and the number of right and wrong answers on the final examination.

Many books have been written about formal adult education, and about how to ensure that maximum learning takes place in a formal setting. Perhaps one of the most helpful of these books is *The Modern Practice of Adult Education*,[1] by Malcolm Knowles.

There is no denying that much valuable learning can take place in a well-structured formal setting, but most adult learning takes place informally. Allen Tough, in his book *The Adult's Learning Projects*,[2] proves conclusively what we all have suspected, that adults learn a great deal on their own, with a little help from their friends and the local librarian. It is a fascinating book and of great importance to adult educators.

The universe of adult education can be likened to an iceberg. The tip is what we see — the workshops, conferences, lectures, seminars, courses — but below the waterline is where the majority of adult education really takes place.

Hospital educators are like solitary fishermen, sailing the North Atlantic in small, fragile boats. Worrying about the tip of the iceberg is formidable enough without concerning themselves with what lies below the waterline. And yet, many facets of the unseen part of the education iceberg can be used to increase the quality, quantity and ease of formal hospital education. The books mentioned above, by Knowles and Tough, give some very practical guidelines.

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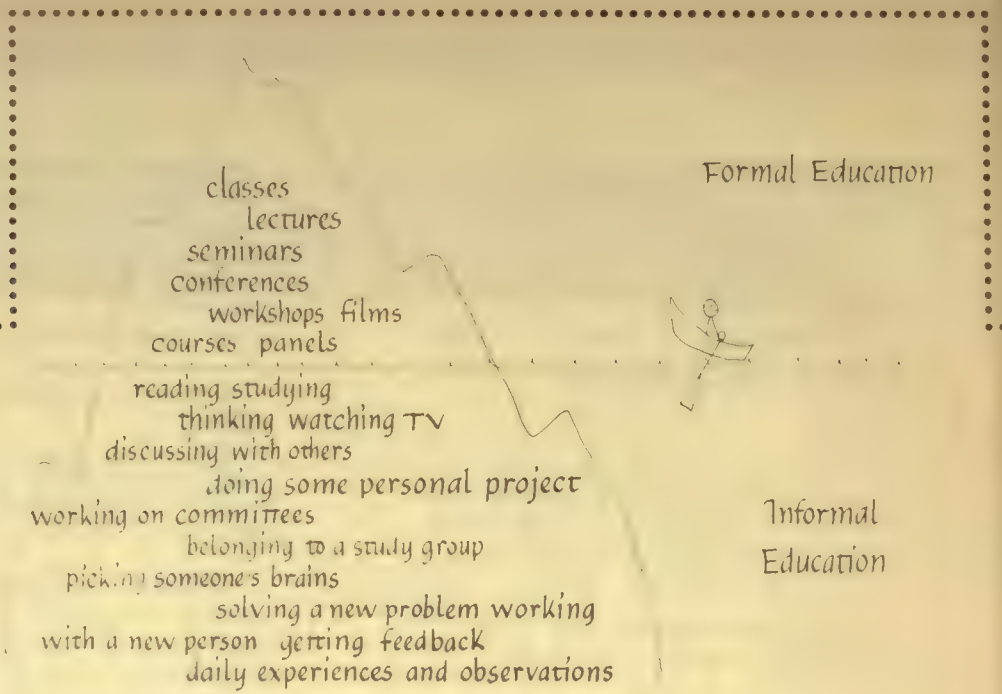
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Key Elements in Adult Education

The key elements of informal adult education are: usefulness, relatedness, control, involvement, other people and support. All of these elements are built right into the adult's informal education and yet they can also be incorporated into the formal setting.

Adults are busy people with many responsibilities. They are inclined to spend their time and energy learning only those things that they consider to be of use to them. It is the responsibility of the hospital educator to find out from the staff just what skills and knowlege would be useful. Knowles does quite a thorough job of outlining methods for gaining this needed information. Once the educator knows what learning the staff considers useful, she can plan a program that they will attend eagerly. Occasionally the educator has a learning program in mind that she considers useful for staff; then she must do a "selling job." If the staff can readily see where the new learning will make their jobs easier or more satisfying, they will consider it useful to attend the program and learn.

Adults also tend to be practical people who put a lot of stock in their own past experiences. Their informal education builds from what they already know, toward what their experience tells them is a desirable goal. If what we want them to learn can be seen to relate directly to their own past experience and knowledge and to their future goals, it is much more likely that they will learn willingly and quickly. If the topic is one that the learners consider useful, it is probably related to their experience and goals, but even then their whole learning experience can be spoiled by the use of language and examples that they can't relate to or don't understand. It is often worthwhile to take the time to have learners verbalize relationships and applications as they see them.

When an adult learns informally, he has a great deal of control over the situation. He decides what the subject matter will be, what learning methods and tools will be used, how quickly the learning will proceed, and when he has achieved his learning objectives. In a classroom setting, the learner frequently relinquishes all of this control to the teacher. The educator who feels secure in her role can return much of the control in the formal learning situation back to the learners. Depending on the nature and breadth of the topic, the learners can decide what sections they will study, how long they will spend on each section, how many practice sessions they will need, what teaching methods they prefer, and even the method and content of evaluations.

Some adults feel most comfortable when the teacher has all the control, but more and more adult learners wish to influence the content and nature of their formal learning experiences. As adults, they are accustomed to being in control of their learning and, by exercising some of this control in the classroom, they are increasing, for themselves, the usefulness and relatedness of the learning.

The more involved a learner is in the learning situation, the more likely she is to thoroughly absorb and efficiently utilize the learning. There are three major areas where learners can become involved in their own formal learning — the content, the process, and the problem.

If the staff has been consulted about what content, knowledge or skills would be useful to them, they have a sense of involvement with the learning program before they even come to class. Once inside the classroom, they need to become directly involved with the content. When we teach skills, we allow ample time for learners to handle the equipment and practice the skills, but too often we overlook the importance of the "hands-on" experience when the content of the program is knowledge or ideas. Learners need time to grapple with new knowledge, debate ideas, draw analogies, and relate what is new to what they already know.

The education process is another area where hospital staff can become involved. If their opinions about teaching formats and methods are solicited, and their suggestions employed, they have a vested interest in making the educational experience successful. If they feel that they have a responsibility for assisting each other in learning, they tend to work harder to avoid letting their co-workers down. Regular evaluations of the content and process by learners, small group discussions, and

group-learning or problem-solving projects foster the sense of involvement and responsibility.

Involvement with a real-life problem that is of importance to people is perhaps one of the most meaningful of all learning experiences. Thomas[3] eloquently argues in favor of the learning value of membership in task forces, committees and other groups that voluntarily come together to achieve a specific goal or solve a certain problem. Hospital educators might want to seriously consider the educational value of staff involvement in various hospital committees.

Tough discovered that in informal education, almost every learner uses four or five other people to help with each learning project. The people used are friends, acquaintances, colleagues, family members and neighbors. They act as resource people in planning the learning, selecting the learning tool, providing information, evaluating the learning, stimulating further learning, and offering support and encouragement. In other words, the adult learner, when learning informally, uses not just one "teacher" but several. Interaction with other people, individually or in groups, seems to be an essential part of the adult education process.

Many adult learners who would eagerly set out to learn anything from astronomy to zoology in an informal manner, resist going to formal education settings, and resist learning once they get there. Perhaps childhood experiences within the school system have left them feeling that they cannot learn, or cannot learn anything useful, in a classroom. They may be afraid — afraid of the content, the teacher, or their own learning abilities. Learning itself is fraught with anxieties and discouragements.

When an adult learns on his own, he builds in a support system. Friends, family members and "that nice librarian" are used as sources of support and encouragement. In staff development education classes, the learner is cut off from these supporting people. Co-workers and superiors may be supportive or they may be non-supportive, even hostile, toward the learner or the learning program. It is the educator's responsibility to help learners build support networks within the class and in the work area.

The Support Network for Adult Learners in Hospitals

The building of a support system is such an important part of a successful staff development program that it deserves more attention here. It is this system that encourages staff to continue learning and enables them to use their new knowledge in the work environment.

A pleasant, relaxed atmosphere in the classroom is the first step toward dispelling old fears about formal education. Course content that the learners know, in advance, is going to be useful, and related to their needs and goals can eliminate a lot of resistance to learning. A teacher who genuinely likes the learners and talks in language they understand, without being condescending, can increase considerably the learners' estimation of their own abilities to master course content. The educator becomes a primary person in the learners' support network. Other people in the class form the ribs of the network. Small and large group discussions, and projects done in pairs or in groups, are conducive to the formation of the classroom support networks that are essential for the effective absorption, understanding and use of new learnings.

Too often educators see people eagerly and happily learning in the classroom, but have "that sinking feeling" that once the learners return to the workplace all will be lost because of a lack of support "out there." Having staff members come to class in pairs or small groups from each area can help develop a support network back at work, but it is essential that the learners have support from key people in the work environment. The educator's and the learners' superiors and co-workers must not only be in favor of the program, but must also be involved, in some way, in the planning, process and evaluation of the program. If staff development programs are to be effective, what the educator does outside of class can be more important than what she does in the classroom.

Just as it is easier to avoid hitting the iceberg if we know what is below the waterline, hospital educators can plan better staff development programs if they understand what adults do on their own to continue learning. The educator who spends the time and effort incorporating these elements into her program not only answers many of those questions educators must ask themselves when planning a program, but is already well on the way to providing a rich and rewarding experience for learners *on their terms.*

Jackie Barber, B.Sc.N., M.Ed., author of "The Tip of the Iceberg," is an independent adult educator living in Toronto, Ontario, whose present positions include those of co-ordinator and instructor, Continuing Education Division, Centennial College of Applied Arts and Technology, consultant and instructor, Nursing Resource Centre, and counsellor and educational consultant, Central Abortion Referral, Education Services, Toronto.

She is a graduate of Atkinson School of Nursing, Toronto Western Hospital, and received her B.Sc.N., from University of Western Ontario, London, and her M. Ed. from the Ontario Institute for Studies in Education.

Barber observes that "although nurses involved in staff development make up only a small percentage of CNJ readers, they are constantly searching for new ideas and for support in lonely positions."

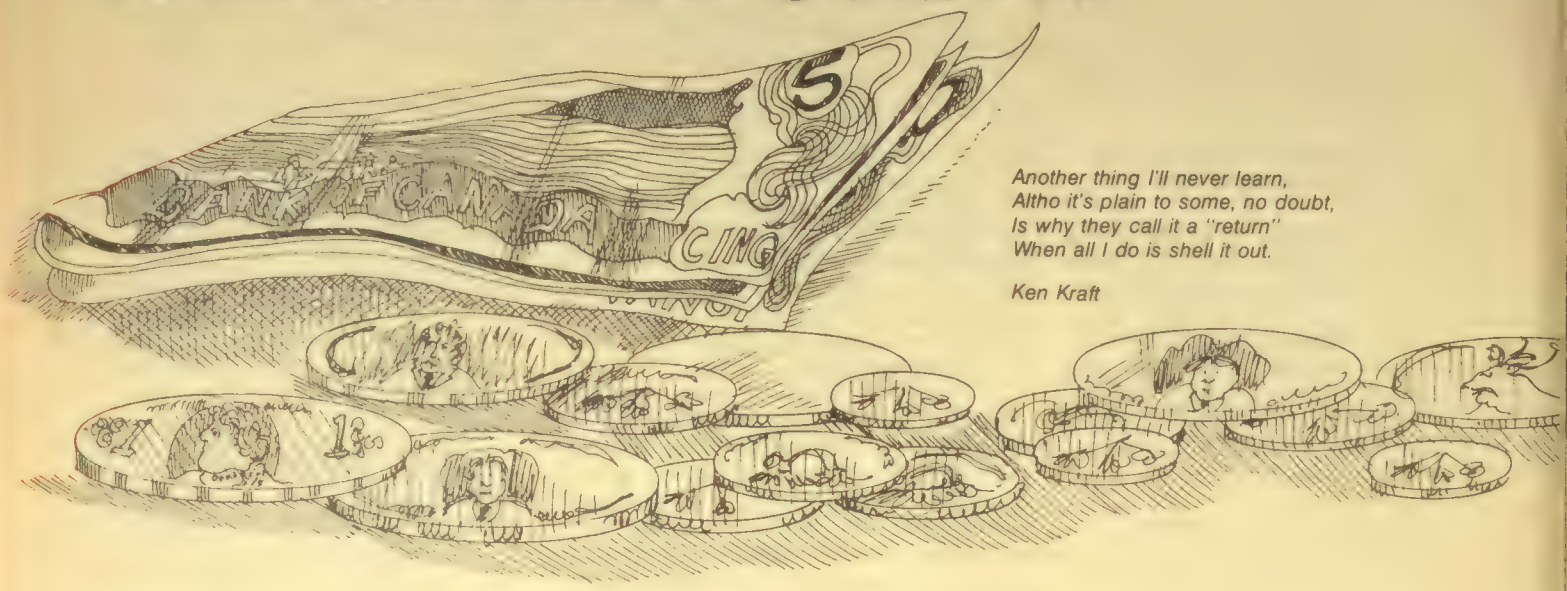
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The Taxman Cometh



Another thing I'll never learn,
Altho it's plain to some, no doubt,
Is why they call it a "return"
When all I do is shell it out.

Ken Kraft

Mike Grenby

A sharp eye can go a long way toward making this time of year considerably less taxing for you. For if you can spot the deductions which people miss most often, you can be dollars ahead when you fill in your income tax return.

I'm going to summarize here a number of points to help you cut your tax bill. I suggest you circle the points which specifically apply to you. (I've indicated where and how Quebec income tax law differs from the federal rules). Then clip this article and refer to it when you prepare your return, supplementing the information here with the guide which accompanies the return.

1 **Make sure you fill in the basic personal details correctly.** If they don't correspond to the information on previous years' returns, the computer will get upset and interminably delay any refund. Also, incorrect marital status or age information can affect your deductions.

2 **If you got married last year, the marriage date is important.** For it's the spouse's net income while married that counts.

Example: If you were married on Dec. 10, your net income for 1976 — while married — might be only about $500. So your spouse can claim almost the whole married exemption for you.

If you earn more than your spouse, then you will probably claim the married exemption.

3 **Declaring all your income is important.** If you forget, chances are the income tax department won't. You'll eventually get a back tax bill, complete with interest and perhaps penalties.

Other income includes scholarships and bursaries over $500. and alimony if received pursuant to a written agreement or court order.

If you're self-employed, phone or write to your nearest district taxation office for form T-2032 (in Quebec, this form is TP-1 and should come with the return), or you can draw up your own statement to attach to your return.

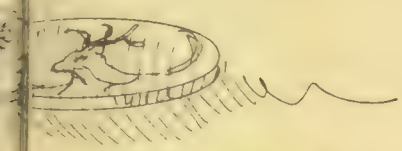
4 **A single person can claim the "equivalent to married exemption" ($1,830.— Quebec, $1,900) for a dependent.**

Example: A single mother could use her youngest child for this exemption; she'd save the others for the child exemption section, where greater age means a greater claim. (In Quebec, the child exemption is only for children 16 or older).

5 **The parent claiming the child exemption must declare the family allowance as income.** (This does not apply in Quebec).

Here again, if the child has earned some money, use the net income (after deductions like tuition, union dues, registered home ownership and retirement savings plan— RHOSP and RRSP — contributions, Canada Pension Plan and Unemployment Insurance Commission payments) when calculating the child exemption.

The annual deadline for completion of income tax returns is fast approaching. So that you can be sure that you're not "shelling out" more than necessary, *The Canadian Nurse* is pleased to offer readers some tips from a recognized authority in the field of money management.



6 **If you were enrolled in an eligible, full-time course last year, you can claim $50. a month for every named month, irrespective of the number of days.**

Example: You were enrolled from March 31 to June 3. You can claim four months — March, April, May and June — even though only 64 days were involved.

This is one of the transferable deductions, so if there's a student in your family, you could benefit.

If the student doesn't need to use the deduction, any other person claiming the student as a dependent (you might be claiming your spouse, child, parent, etc.) can use this deduction. (Not in Quebec).

7 **Another transferable deduction is the interest-dividend deduction: the lesser of the actual amount or $1,000.**

So if your grossed-up dividends (actual dividends times four-thirds) plus interest come to $400, for example, you claim $400. If the total were $1,200, you'd claim $1,000.

And if one spouse has interest or dividend income but little or no other income, the other, higher-income spouse may be able to use the transferred deduction.

8 One accountant I talked to felt that in the **"employee expense"** section, a nurse working as an employee might also be able to claim the cost of uniforms and other necessary equipment such as a stethoscope as "other allowable expenses." Keep receipts to back up this claim, in case it is allowed — although income tax officials I talked to disagreed with the accountant on this.

9 **If you had more than one employer last year, chances are you over-contributed to CPP (in Quebec, QPP) or UIC.** There's a place on your return to make this calculation.

10 **You must have an official receipt for any RRSP or RHOSP contribution before you can deduct it,** and if you contribute in January or February, you probably won't get the receipt until March or even April.

If you have a refund coming without the contribution, go ahead and file your return. Then when your receipt arrives, send it off with a note asking the tax people to include this deduction.

11 **Tuition fees over $25 paid to the same institution can be claimed by the student.** This is in addition to the transferable education deduction mentioned earlier.

12 **To claim child care payments, you must include the name, address and social insurance number if possible of the person you paid.** You must have receipts on file but needn't submit them.

13 **If you moved more than 25 miles to a new job last year** — and this includes a student moving to take up a first job — you can deduct all expenses connected with the move for which you were not reimbursed.

And don't forget the commission when you sold your home. If you did forget this in the past, you can ask to have your return reassessed; depending on your tax official, you might be able to go as far back as the 1973 tax year.

14 **All expenses (except commissions) related to investments are deductible.** Don't forget safety deposit box rental and the interest paid on the instalment or payroll deduction plan to buy Canada Savings Bonds.

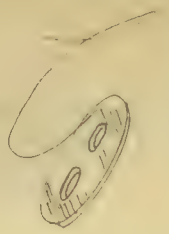
15 **Alimony is deductible only if payments are made pursuant to a written agreement or court order.**

If you've marked some of these points but still feel unsure about preparing your own return, consider paying around $25. — although the fee could be as low as $10. — to have a professional do the job for you.

Ideally, pick somebody with an accounting background and most important, somebody who will be around all year. This contact with a professional could also help you with your general personal finances, not only taxation.

If you do your own return, your local district taxation office offers free answers to all questions. Unfortunately, this information is not binding; at worst, you could get three different answers to the same question from three different people.

So if a large deduction is at stake in a fairly complex matter, always realize that you might get an assessment notice disallowing it and don't spend your rebate until you actually get it.



Recommended reading:

- Some 15 different income tax department booklets, available free by phone or mail from your local taxation office.
- David Ingram's *Guide to Income Tax in Canada* and Thomas Ferguson's *What to Do When the Taxman Comes*, both International Self-Counsel Press Ltd.; around $3. each.
- Preparing Your Income Tax Return, by Lachance and Eriks; CCH Canadian Limited; around $6.
- Check your library or bookstore for other titles; several of the CCH income tax titles are in French, too.



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If you have any questions on your personal finances involving investment; insurance, banking, credit or any other such matters write to me c/o *The Canadian Nurse*.

While I cannot reply individually, I will answer as many questions in this column as space allows.

Letters must be signed, but only your initials will be used if you so request.





Mike Grenby *whose tips on preparing your income tax return appear above, is on the staff of the Vancouver Sun, lectures and appears regularly on both local and national radio and television, and has done consulting work for the federal government.*

He is the author of a nationally syndicated column that he says he writes "to help ordinary people understand, manage and get the most from their money." Last year, he received the Toronto Press Club and the Royal Bank of Canada's National Business Writing Award for "the best business column in Canada."

A graduate of the University of British Columbia and Columbia University Graduate School of Journalism, he is the author of "Mike Grenby's Guide to Fighting Inflation in Canada" (International Self-Counsel Press Ltd.). He and his Australian-born wife, Mandy, who is a nurse, live with their son, Matthew, in West Vancouver.

Crossword Puzzle ANSWERS

Down

2. excrete
3. ilium
4. coccidioidomycosis
5. neo
6. rhythm
7. debridement
8. venogram
9 ligament
10. optic
12. bifurcation
16. urtica
18. adapter
19. dacryo
21 acapnia
22. abdomen
24. CBD
26. areola
27. hyper
28. butyrin
29 galact
31 tic
33. neck
34. disc

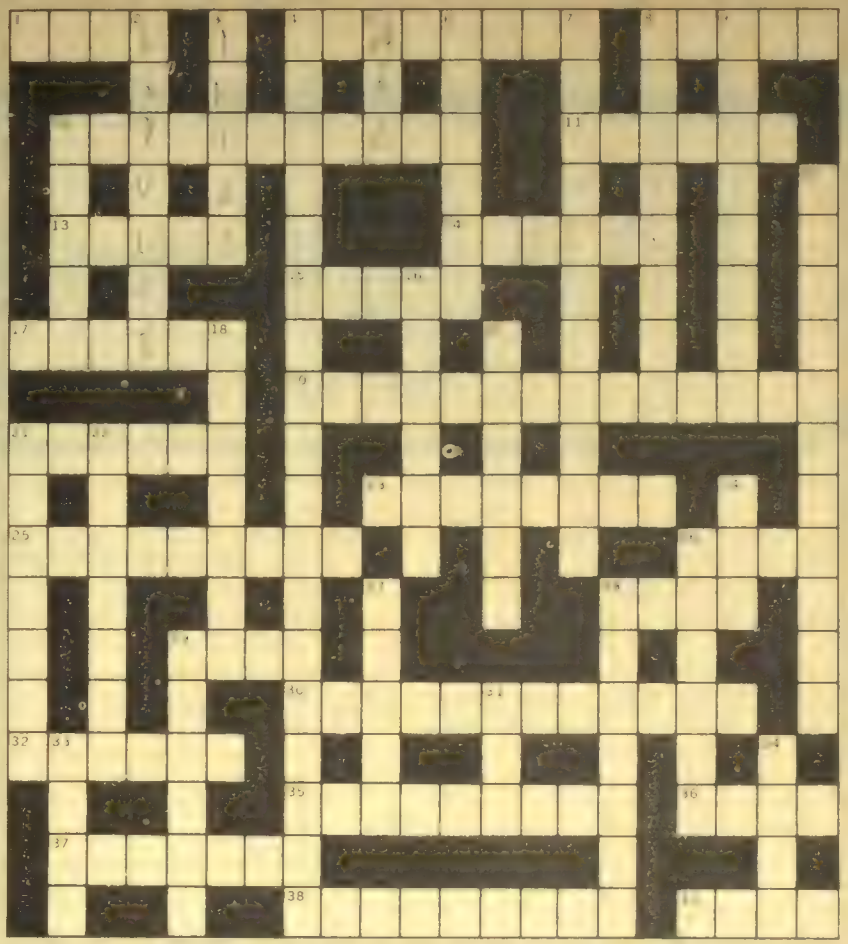
Across

1. dose
4. cancroid
8. valve
10. orchiectomy
11. benign
13. therm
14. Hering
15. datum
17. sclera
20. ophthalmometer
21. abasia
23. scorings
25. adduction
26. abut
28. Bird
29. gray
30. capistration
32. annuli
35. stretcher
36. acid
37. calculi
38. striation
39. face

Crossword Puzzle

Maria Rubilie Glenn

For those who have been doing the clinical wordsearch puzzles, here is a new slant — a crossword puzzle of nursing and medical terms. If you have difficulties, all the words and their definitions are taken from *Dorland's Illustrated Medical Dictionary,* Philadelphia, W.B. Saunders Co., 1965. Answers on page 38.



DOWN

2. To throw off, as waste matter, by a normal discharge.
3. The expansive superior portion of the hip bone.
4. A disease caused by infection of the lungs. It is marked in initial stages by symptoms resembling those of pulmonary tuberculosis, with erythema nodusum. The disease may progress to a generalized form.
5. Combining form meaning new or strange.
6. Recurrence of an action or function at regular intervals.
7. Removal of all foreign matter and devitalized tissue in or about a traumatic or other lesion.
8. Roentgenography of the vein or veins.
9. A band of tissue that connects bones or supports viscera.
10. Referring to the eye.
12. Division into two branches or site where a single structure divides into two.
16. A wheal or pomphus.
18. Device by which different parts of an apparatus or instrument are connected.
19. A combining form meaning relationship to tears.
21. A condition of diminished carbon dioxide in the blood.
22. That portion of the body which lies between the thorax and the pelvis.
24. Acronym for common bile duct.
26. A circular area of different color surrounding a central point.
27. A prefix signifying above, beyond or excessive.
28. A glyceride existing in butter or liquid fat with an acrid, bitter taste.
29. Combining form denoting relationship to milk.
31. Any spasmodic movement or twitching.
33. A constricted portion, such as the part connecting the head and trunk of the body, or the constricted part of an organ, as of the uterus or other structures.
34. A circular or rounded flat plate or organ.

ACROSS

1. A quantity to be administered at one time, such as a specified amount of medication.
4. A skin cancer of a moderate degree of malignancy.
8. A membranous fold in a canal or passage, which prevents the reflux of the contents passing through it.
10. Excision of one or both testes.
11. A word meaning not malignant.
13. A unit of heat.
14. A test for vision determining if the subject is binocular or monocular. Named after a physiologist in Leipzig, (1834 - 1918).
15. Material or fact on which a discussion or an inference is based, (singular).
17. The tough white supporting tunic of the eyeball.
20. An instrument for measuring the eye, especially one determining its refractive powers and defects by measuring the size of the images reflected from the cornea and lens.
21. The inability to walk due to a defect of coordination.
23. Small transverse lines caused by increased density of the bone, seen in x-rays at the metaphysis of growing bones and due to temporary cessation of growth.
25. The act of drawing toward a center or median line.
26. A word meaning to touch, adjoin or border upon.
28. A sign indicating a definite zone of dullness with absence of the respiratory sounds in hydatid disease of the lungs. Named after an Australian physician, (1832-1904).
29. Color hue between white and black.
30. Another term for Phimosis.
32. A ringlike or circular structure. (Plural).
35. A litter for carrying the sick or injured.
36. A compound that reacts with a base. Sour, having properties opposed to those of the alkalies.
37. Abnormal concretion occurring within the animal body and usually composed of mineral salts, (plural).
38. A quality of being marked by stripes, a streak or scratch.
39. The anterior aspect of the head from the forehead to the chin inclusive.

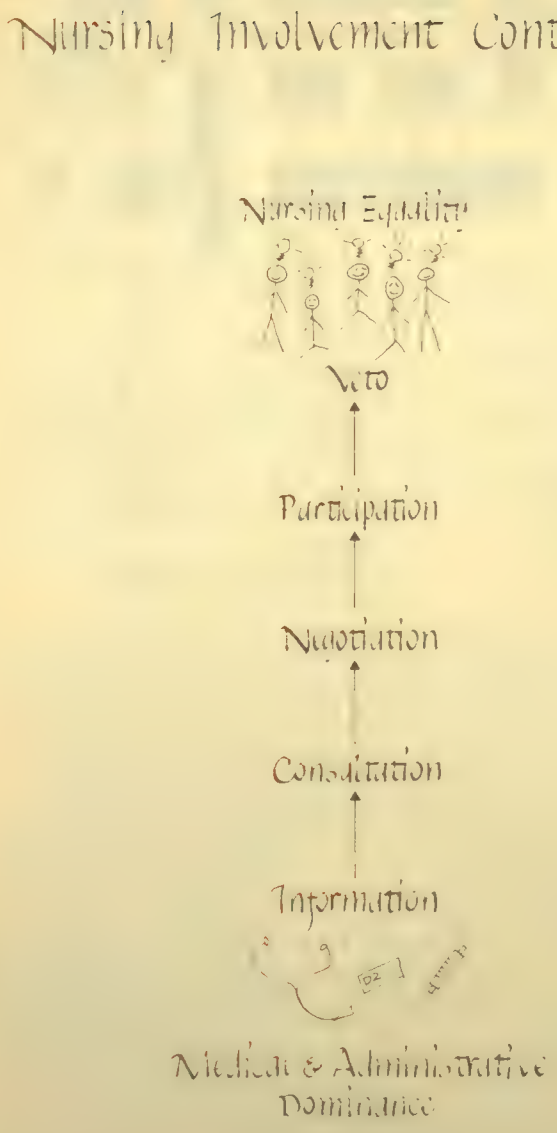
Author's Note

Maria Rubilie Glenn came to Canada in 1965 from the Philippines after receiving her basic nursing education. She has worked as a general duty nurse and as an OR nurse at various hospitals before completing her B.Sc.N. at the University of Alberta, Edmonton. She states: "I find crossword puzzles an excellent way to learn new words. I hope that the readers of The Canadian Nurse will enjoy and benefit from solving this particular puzzle just as much as I enjoyed developing it."

Challenging the Status Quo:

the nurse's role in health care delivery planning

Heather F. Clarke



"Nurses have already made concrete suggestions about ways of responding to the needs: home care, use of the public health nurse, ... etc .... What is needed is an unbiased assessment of alternative services in terms of their relative low cost, effectiveness and social importance. This will require a concerted and imaginative effort by the consumers of care, the health workers and government. Nurses are willing to enter into such a partnership."[1] Thus the Canadian Nurses Association has supported the necessity for nurses to get involved in health care planning and challenged other parties to recognize nursing input. The real challenge, however, is whether nurses will rise to their responsibility in health care planning with the energy and commitment necessary to *make* significant input.

For most nurses, involvement in the planning of health care services is still a new concept. Traditionally we have been taught to accept the role of implementor of medical and administrative decisions and, until recently, were content to stay in that role. The nurse's responsibility for planning and evaluation of health services was rarely mentioned because, officially, only medical services existed. Today, however, more and more nurses are concerned that their professional responsibilities go beyond direct nursing care to cooperating with others in the planning, implementation and evaluation of health care delivery. From their unique perspective, nurses are beginning to challenge the status quo of the health care system, to get elected to hospital boards, and to agitate for the changes they regard as necessary to focus health care delivery on the total needs of the client rather than the goals of professionals (ie. physicians).

The kind of adaptive planning that has been used in the past is outdated and ineffective; the need today is for positive, innovative, developmental planning. The modern health care system must put its emphasis on health maintenance and prevention, increase its capacity to locate those at high risk, and identify groups requiring preventive and long-term care.

In their struggle to achieve wider recognition and more responsibilities, nurses have been breaking into areas from which, in the past, they have been excluded. One of these is the field of health care planning. In The Canadian Nurse, *March 1976, Bernadet Ratsoy described a strategy the individual nurse could use to promote her own ideas for change. Here, Heather Clarke outlines the role of the nurse in health care delivery planning and the part played by the RNABC Committee on Health Care Delivery in promoting nursing participation in this area.*

Because nurses represent the largest group employed in health care delivery and are closely associated with the consumers of existing services, their participation is needed for effective management of the community's total health care resources, for improved communication between the providers and consumers of services, and for better distribution and quality of health care services. Thus our involvement must include not only planning for the nursing component of health services but for those services in their totality.

To become involved to this extent in health care planning, we must change our conservative attitudes and recognize that our responsibility is to the client, not only to the system. We must accept the challenge and responsibility for defining our roles in broad, functional terms rather than narrow and task-oriented ones. The preoccupation of nursing with its own problems must give way to a closer collaboration with others, with extensive participation in the community health care planning process.

In B.C., for example:

- nurses have been elected to hospital boards in their community;
- in one region a nurse has been appointed to the Union Board of Health;
- nurses were included in advisory committees to the new Maternal-Child-Pediatric Health Care Complex;
- nurses have become part of an interdisciplinary team approach to community services that involves the integration of social work and health services. These changes would not have happened without the work of individual nurses who were forward-looking, committed to their cause, and not afraid of the hard work involved to make their goal a reality. It was only through insistence, pressure, follow-up, time and energy that even such small victories were won. (See Ratsoy, *The Canadian Nurse,* March (1976).[2]

To further promote the effective participation by nurses at the policy- and decision-making levels of both elected and appointed bodies which affect health care delivery, the RNABC Board of Directors established the Committee on Health Care Delivery in March 1975. At the 1975 RNABC Annual Meeting delegates and participants identified deterrents to nursing involvement in health care delivery, the four most significant being apathy, lack of confidence, lack of knowledge and training, and the traditionalism of the health care system. Suggestions for change involved personal, professional and educational committments. Although Committee members were interested in studying these concerns and developing specific objectives, they first had to answer a number of questions: how do we initiate involvement; how much input should we have; who should be involved; and what are the priorities?

During the year of its existence, the Committee on Health Care Delivery studied issues and made recommendations to the RNABC Board of Directors to:

- communicate with federal and provincial governments indicating the Committee's terms of reference and commitment to active involvement in health care planning;
- examine the internal committee structure of the RNABC, emphasizing the need for coordination;
- support nursing responsibilities at the IXth International Conference on Health Education by participation and financial support, and
- promote recognized formal nursing input to hospital boards by a change in hospital bylaws.

Many other issues were identified but again, priorities had to be set.

The model of involvement (see diagram) the Committee used to promote nursing input in health care planning can best be illustrated by taking the case of changing hospital bylaws. The first step, or minimal level of involvement, is *information sharing.* This is an essential precondition for participation, since it is the only way of ensuring that intelligent choices are made. Each nurse must be informed about the current situation, past experiences and alternative solutions — in short, she must know what she is talking about. The Committee's concern for formal, recognized nursing input to hospital boards meant that each member had to be knowledgeable about the present situation, the results of any previous studies and government reaction, and the strategies and alternatives used in other provinces. We studied the hospital bylaws, shared information and came up with a recommendation.

The second level of involvement, *consultation,* is built upon information. Is the informed nurse consulted when planners are making investigations and recommendations? Is she/he visible to the planners? Because those involved in planning are still frequently unaware of nursing expertise and interest in becoming involved, we had to present our recommendation on bylaw changes to the RNABC Board of Directors and get their support to present a brief and recommendations to the Minister of Health. At the same time, nurses concerned with health care planning in the community and RNABC officials joined committee members in a series of activities that served to increase our visibility. These included: submitting petitions of concern to the government and indicating willingness to become involved in planning (eg. regarding cutbacks in Home Nursing Program); submitting letters of concern and resolutions to the RNABC Board of Directors requesting action; issuing press releases and statements regarding controversial health issues.

Involvement at the first two levels is relatively passive and it is usually up to the discretion of the bureaucracy or physicians whether they will take nursing interests seriously. As nursing involvement becomes more pronounced and active, however, there will be a movement toward *negotiation.* This is a bargaining situation between planners and decision-makers, demanding a greater degree of equality. In our society

this stage is largely a political process. Can we persuade government to adopt our ideas or change their stand? Can we get the hospital bylaws altered to include formal nursing input to hospital boards? In our case, the brief requesting a change in hospital bylaws was presented to the Minister of Health and his Deputy Ministers. They agreed in principle to the change, suggesting we return with alternative methods after discussing them with the medical and hospital associations.

Negotiation leads to the next level of involvement, *participation* in the decision-making process. This has been graphically described by Bernadet Ratsoy(*The Canadian Nurse,* March 1976) in her article about the steps she took to promote the implementation of a Family-Centered Maternity Health Unit in her hospital.

Only after the nurse has progressed through the other levels of involvement and established credibility as a planner of health care delivery will she reach the strongest form of participation in planning and decision-making, the *Veto.* At this stage the nurse has attained enough respect in her field that a recommendation by her withholding support for a certain aspect of the plan is accepted by other planners as reason enough to alter the plans.

Successful planning is based on policy and strategy as well as on coherent gathering and organization of reliable data. Nurses, then, must rely on their political abilities as well as their professional knowledge and skills in order to influence the world in which they live. In general, nurses have lacked political consciousness. We have had the potential for power, in fact, we have had power, but we have not used it effectively. The potential power lying unused and dormant in our profession is colossal. Writing in *Nursing Outlook,* JoAnn Ashley noted that "...nursing has, and always has had, power; it is essentially a social phenomenon and its power derives from society's recognition of nursing as an essential service. The problem lies in the ways in which nurses have used, misused, and abused their power (or failed to use it at all) and in the system in which nursing developed and is now practiced."[3]

Power and freedom must always be taken. They are never given to oppressed groups. Part of the problem lies within nursing itself, as Dorothy Hall stressed in her address to the RNABC Annual Meeting in May 1975: "One of the reasons we have been excluded from planning is because we may never have indicated that we wanted 'in.' Where we have done so and continued to be excluded, we have perhaps failed because we lacked an alternative strategy or because we have not been prepared either to persist or insist."[4]

Success in politics depends on commitment and energy, clear goals, thoughtful planning and a sense of humor. Nurses must arrive at the conclusion and conviction that it is morally right for them to seek power, freedom and recognition. A clear presentation of our motives is essential, devoid of the confusion, misconceptions and fears that so often accompany efforts to attain these goals.

Whether it is bedside care, service planning and control, or teaching, nurses are already involved in decision-making. Even if by default, we cannot escape certain actions that ultimately make services available to some and deprive others. It is time we started to recognize that as nurses we have a dual responsibility; as citizens and as health care professionals. We must stop being passive about health care planning and participate directly, in a planned, strategic way, armed with knowledge, experience and commitment.

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Heather F. Clarke *is herself an active promoter of progress on the nursing front. She was involved in the Expanded Role of the Nurse Program of the University of British Columbia, is a member of the Board of Directors of Vancouver Planned Parenthood and of the Social Planning and Review Council of B.C. (SPARC) and was resource person for the IXth International Conference on Health Education held recently in Ottawa. She was chairman of the Health Care Delivery Committee of the Registered Nurses Association of B.C. and of the program committee for the 1975 RNABC annual meeting. Her present position is Nursing Consultant to Community Human Resources and Health Centres in B.C. and World Health Organization (WHO) Consultant to the University of Iceland. School of Nursing.*

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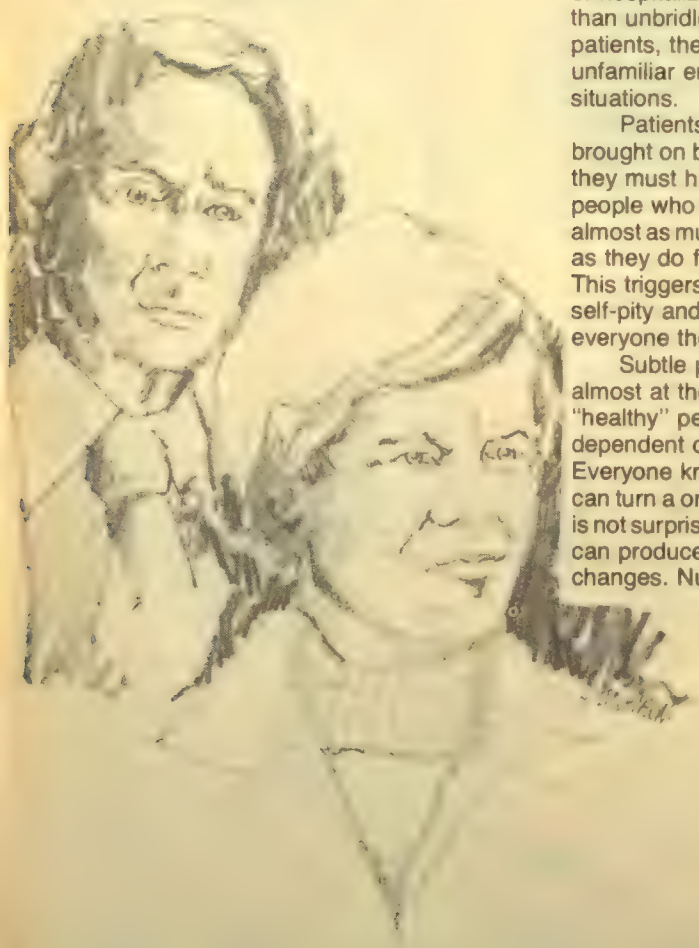
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HOSPITALIZATION AND PERSONALITY CHANGE: RECOGNITION VITAL TO NURSING CARE



Gertrude M. Lake



Hospital nurses sometimes forget that adults as well as children face the thought of hospitalization with something less than unbridled enthusiasm. For most patients, the hospital is, at best, an unfamiliar environment full of stressful situations.

Patients often endure mild stress brought on by their illnesses long before they must have hospital care. Healthy people who fall ill unexpectedly suffer almost as much from a loss of self-esteem as they do from their physical ailments. This triggers such reactions as morbid self-pity and hostility directed at nearly everyone they encounter.

Subtle personality changes begin almost at the moment the former "healthy" person is forced to become dependent on others for assistance. Everyone knows how the common cold can turn a once sunny disposition sour. It is not surprising, then, that hospitalization can produce dramatic personality changes. Nurses who recognize these changes and understand why they happen, are in a position to take appropriate measures which will reduce emotional stress as much as possible. There can be little doubt that nursing care which takes into account patient personality change is essential to the speedy recovery of the sick.

People who try to ignore an illness, often become angry when they must accept the truth. For almost a year Howard put off having a hemorrhoidectomy. Finally, one of his co-workers told him he was grumpy and he knew he had to do something. The pain had increased to the point where it was affecting his work and his relationship with his co-workers. When he accepted the inevitable, he reacted by cursing the fates and indulging in self-pity.

John was in no position to "find the time to be sick." He was in agony with an inflamed appendix. His only thought was to get instant help to relieve the pain. Because it was impossible to perform miracles, he became hostile towards the nurses. When relief finally came he regained his self-control and was able to accept the reassurances of the nurses.

Although their experiences were in marked contrast, both men displayed the same reaction — anger — at the outset. Eventually anger will begin to subside as hospitalized patients enter an adjustment phase.

The importance of a good nurse-patient relationship cannot be overstated. John and Howard could have been very difficult patients if their nurses hadn't taken the trouble to figure out why they behaved the way they did.

Dependency

During this stage, patients see themselves as passive recipients of help, having given up their normal rights over their own bodies. They feel helpless, completely dependent on nurses for everything. In the acute phase of an illness patients must have an abiding trust in those looking after them. If the trust is broken, emotional and physical setbacks are highly probable.

At this point during his hospital stay, Howard began to worry about what he perceived as inconsistencies in his nursing care. His anxiety took such a hold over him that he was unable to question the nurses.

A flippant reply to a question from John had similar consequences. When told that a nurse could not help him because it was time for her to go home, John felt his legitimate concerns were being ignored. It took him many days to get over the incident; this would not have happened if the nurse had merely advised him that her replacement would look after his needs.

Recovery

Later, patients begin to feel they are participating in their recovery.

Howard showed an interest in learning about necessary diet changes. John made less frequent requests for pain relievers.

At this stage, however, patients are still a long way from regaining confidence in their abilities to look after themselves. Both Howard and John felt the nurses were neglecting them, an indication their ailments still dominated their personalities.

Because normal life styles are altered, hospitalization tends to break the continuity of life. The bed, food, room, people, smells and routines are not like home. Family members can often provide help to bridge this gap by bringing "home" to the hospital. A few personal possessions, such as photographs of the patient's family, news about happenings at home, and even a little home cooking may help the patient maintain his sense of personal identity.

It is important that nurses know how patients react to the hospital scene so that they can work with them to set health goals. Because this involves the patients, they have a greater sense of control over their situations.

Nurses should only get involved in areas where patients cannot help themselves. The ultimate aim is to create a process which allows patients to play a greater part in helping themselves. However, at this point they are still mainly in a receiving position.

Getting involved

Nurses could alleviate much of the initial trauma for patients and reduce their own workload if they became involved as soon after admission as possible.

The nurse-patient relationship is the first step in helping patients. In varying degrees nurses must reach out to patients and establish workable systems of communications. Essentially, patients should feel they have the right to ask questions and that nurses will respond.

To return to John and Howard for a moment, their involvement in nursing care helped them to learn what was expected of them and how they could help themselves increase their understanding of treatment plans. All this was necessary in the battle to regain their self-confidence.

Both nurses and patients must be honest and concerned about the effects of hospitalization. Young nurses should not be reluctant to consult more senior nurses in order to answer patient questions. The student nurse who was answering Howard's questions, for example, often turned to experienced nurses for the answers. Howard found this reassuring as he felt the nurse was giving him accurate and valuable data and had a genuine interest in his well-being. Howard expressed a lack of concern from the "higher up" nurses who were more interested in running the ward, and were not available to help the patients. The nurse needs to have a relationship that indicates her receptiveness to the patient. She needs to feel comfortable with him, not pass judgment, and be honest to herself about her own biases. She must listen to the intent of communication — not just the words she hears, but also the nonverbal messages.

Finally, openness is extremely important. Patients should be encouraged to express their feelings, to let the nurses know what is bothering them, even though it may not be directly related to a medical problem.

In an era when many people feel alienated by an impersonal society, nursing should once again emphasize the value of establishing meaningful human relations as an integral part of medical care.

Author **Gertrude Lake** *of Burnaby, B.C. (R.N., B.S.N., M.S.N.,) is program co-ordinator for the first year of nursing for Registered Nurses and Registered Psychiatric Nurses at the British Columbia Institute of Technology. She was responsible for the integration of mental health nursing concepts and skills into the BCIT program before becoming co-ordinator. Lake is a graduate of the University of British Columbia and received her M.S.N. from the University of California, San Francisco Medical Center. She describes this article as "the beginning of my organization of my beliefs concerning nursing assessment" and says: "I fully believe that assessment for emotional components in patient behavior and in illness need not be complicated, nor time-consuming. Nursing needs to identify a select assessment tool which includes critical components that will lead to identification of problems that are emotional or have emotional overtones."*

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Names and Faces

Eliane Lacroix, French translator at the Canadian Nurses Association, is retiring after 13 years of service. During her stay at CNA, she has been solely responsible for the translation of many articles in *L'infirmière canadienne* and all the official documents, annual reports, position papers and minutes of CNA meetings into the French language. Her translation abilities have been utilized by the library and Information Services at CNA as well as by many French-speaking nurses in Canada.



Before coming to Ottawa, Lacroix worked for the purchasing division of the French interim government in Washington, the French Embassy in New York and until 1963, for the French official tourist board in Montreal. She will be greatly missed by her colleagues who value her integrity, dedication, experience and sense of humor.

Henriette Gravelle, formerly with the Council on Social Development, replaces Lacroix as CNA translator and **Jacques Paris** takes on the position of revisor of translation.

Marlene A. Grantham (R.N., Atkinson School of Nursing, Toronto Western Hospital; P.H.N., B.Sc.N., University of Western Ontario; M.Sc. (Admin.), McGill University) has recently been appointed Director of Nursing Service, Victoria General Hospital, Halifax, Nova Scotia. Leaving her position as Regional Director of the VON, she brings a variety of clinical and community health experience to her new appointment.



Grace Batchelor has been appointed Co-ordinator of Continuing Education, Division of Community Health by the University of Toronto, Faculty of Medicine. Batchelor holds a B.Sc. in biophysics from McGill University and a Master of Health Services Administration from the University of Alberta. She has previously worked as a research associate in the Department of Clinical Epidemiology and Biostatics at the McMaster University and as a health consultant with Systems Dimensions Ltd.



Jeff A. Bloom has joined the staff of the Division of Community Health, Faculty of Medicine at the University of Toronto. Bloom will be secretariat of the Primary Care-Outreach Project Committee, a multi-faculty task force working on developing a demonstration model of a multi-faculty primary care unit with involvement from the five health science faculties and the School of Social Work.

Previously, Bloom was the Evening Administrator at Belleville General Hospital, Belleville, Ontario.

Norah A. O'Leary (R.N., Toronto General Hospital School of Nursing; B.Sc.N., M.Sc.N., University of Toronto) has recently been appointed Nursing Consultant, Health Consultants Directorate, Health Programs Branch of Health and Welfare Canada. When asked to comment on her new position, she stated, "Its primary objective is the improvement of the delivery of nursing care in institutions. This objective is met in a variety of ways. The Nursing Consultant acts as a member of a multidisciplinary team which assesses and makes recommendations for improvement in the areas of organization, administration, operation and patient care delivery in an individual hospital. Consultative services are offered to provincial authorities, and through them to individual Nursing Service Departments. There is an opportunity to participate on federal-provincial working parties developing standards for various hospital departments. A function which I perceive as very important is to facilitate communication between nursing groups throughout the country."

O'Leary is President of the Ontario Lung Association Nurses Section and is past assistant professor, School of Nursing, Lakehead University in Thunder Bay, Ontario.

Phyllis Craig (B.Sc.N., M.H.S.A., University of Alberta) has been appointed a full-time researcher with the Edmonton Local Board of Health. She says "Administration and research in health disciplines should be interrelated. The research program need not be large, but at least decisions are based on some statistical findings."

Craig's nursing career has included two years with Health and Welfare Canada at Norway House, Manitoba; short-term nursing assignments in Australia; and work as a public health nurse and nurse practitioner in Alberta. Her recent studies in health services administration were in part supported by the Canadian Nurses Foundation.



Anne Dykstra (R.N., Brantford General Hospital, Brantford, Ontario) recently arrived, with her family, in Solo, Indonesia to join MEDICO, a service of CARE. She will conduct in-service training sessions for Indonesian student nurses and nursing staff from outlying district hospitals. She was previously assigned to Malawi as a volunteer for CUSO.

New Appointment

Iris Passey of Vancouver is representing the RNABC on the Forensic Nursing Committee of the Registered Psychiatric Nurses' Association.

Awards

The New Brunswick Association of Registered Nurses has awarded $4500. in scholarships to students enrolled in university nursing programs.

At the Master's level, **Dorothy Wasson,** R.N. at McGill University receives $1500., and **Cheryl Doiron** R.N., enrolled at the University of Ottawa receives $500.

At the Baccalaureate level, **Carole Estabrooks** at the University of New Brunswick, **Kathryn Suttie,** at Dalhousie University, and **Nicole Girouard** at the University of Moncton, receive $500. scholarships. The annual Muriel Archibald scholarship was awarded to **Columbienne Bernard,** at the University of Moncton and **Paula Quinn** at the University of New Brunswick.

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5 5	90-150 lbs	155-200 lbs
5 6	90-150 lbs	155-200 lbs
5 7	95-145 lbs	150-195 lbs
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4 11	105-135 lbs	-	-
5 0	100-140 lbs	-	145-180 lbs
5 1	95-145 lbs	-	150-185 lbs
5 2	90-140 lbs.	141-150 lbs	155-190 lbs
5 3	90-135 lbs	136-155 lbs	160-195 lbs
5 4	95-130 lbs.	131-160 lbs	165-195 lbs
5 5	100-125 lbs.	126-165 lbs	170-195 lbs
5 6	105-120 lbs.	121-165 lbs	170-190 lbs
5 7	110-115 lbs	116-165 lbs	170-185 lbs
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Books

Barriers and Facilitators to Quality Health Care, by Madeline Leininger (ed.). Philadelphia: F.A. Davis Co., 1975.
Approximate price $9.60
Reviewed by Colleen Stainton, Assistant Professor, Faculty of Nursing, University of Calgary, Calgary, Alberta.

"Health care is an expected, essential, and important societal imperative in our culture." So says Madeline Leininger at the beginning of her chapter in this interesting book. While most of the content deals with the health care system in the United States during the past two decades, the book provides some thought-provoking reading for health professionals in other countries.

Various authors examine major issues and generate some common themes among the barriers and facilitators of health care. Barriers tend to be identified as: poor planning; lack of coordination and cooperation among the rapidly increasing numbers of health care professionals; inefficient use of economic and manpower resources; and changing consumer demands. Some facilitators suggested are: communication and coordination of the professionals; improved health team education; improved health policy leading to more primary, ambulatory care facilities; and changes in the role of the health professionals.

The chapters are arranged logically, beginning with an historical review of the last decade by Loretta Ford, who focuses on health manpower use and changes needed. The next chapter by John Bryant, an Associate Dean of Medicine, examines Health Care Trends and Nursing Roles, and provides some comments highly relevant to current planning in both education and service in nursing. He makes interesting suggestions for dealing with some of the problems in health manpower resources, and discusses nursing as an important profession in providing the answers to these problems.

A chapter by a dental professor outlines the strengths and weaknesses of dentistry as part of the health team, especially in the area of prevention and early diagnosis of medical problems. Nancy Keller, a doctorate nurse with a private nursing practice, discusses the facilitators and barriers to this type of health care delivery. She adamantly supports the view of the nurse in the extended role as a "client-extender" vs. a "physician-extender."

Dr. McCormack, a health care planner, in a chapter entitled "Public Policy and Medical Care Evaluation" examines the organizational structure of the health care system in the U.S.A. and the evolution of public policy. He evaluates the response of the professions and makes a strong plea for peer review as a means to ensure quality. Then, Drs. Saward and Greenlick in "Health Policy and the HMO," (Health Maintenance Organization) comment on the effect of the prepaid medical programs established in the U.S.A. in 1965 and end the chapter with a plea for more medical research in the area of health. These chapters clearly detail for the reader the current health care delivery system in the U.S.A. and strenuously evaluate it.

The final three chapters are focused on predicted and tested ways of improving the present system. Madeline Leininger describes health care behavior from an anthropological perspective in a fascinating chapter entitled, "Health Care Delivery Systems for Tomorrow: Possibilities and Guidelines," strongly advocating an open system and consumer choice of the type of health practitioner appropriate to their health needs.

The book concludes with two chapters by Canadian authors. The first is about the nurse practitioner program at McMaster University and is written by Walter Spitzer and Dorothy Kergin. The famous Southern Ontario Randomized Trial of nurse practitioners in doctors' offices is described by W.O. Spitzer, M.A. Yoshida and B.C. Hackett in the final chapter.

It is notable that the profession of Social Work is not represented in the list of authors.

The book was edited with an impressive advisory board of nursing leaders and a group of special consultants from dentistry, pharmacy, nursing and medicine. It is a book that would be a useful reference for those studying health care administration and policies. It documents needed changes in focus of health care delivery from curative to preventative care. The nurse practitioner is strongly supported as a logical means of providing this type of care.

Health care research is alluded to on occasion in this book but one would expect it to be mentioned more often as a facilitator and for some stress to be placed on interdisciplinary health care research.

The book, while only 118 pages long, is heavy reading. The highly-qualified authors have taken considerable care to document the content of their chapters. Extensive bibliographies follow most chapters.

This text provides information of use to faculty and those in graduate programs in all health professions. It would probably have somewhat limited use by undergraduate students but should be available to them. The extensive index is an excellent reference on special or specific areas covered by the several authors. I would recommend it as a good reference for all those holding office in professional associations, for the library holdings of all professional faculties and schools, and certainly for those serving on special action committees studying the health care delivery system in any country.

Correction

In November, credit for reviewing *Freedom to Die: Moral and Legal Aspects of Euthanasia* by O. Ruth Russell, was mistakenly given to Harriett Hayes, Director of the Miss A.J. MacMaster School of Nursing. The review was in fact written by Sharron Woodworth, Instructor, The Miss A.J. MacMaster School of Nursing, Moncton, New Brunswick.



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Calendar

February

Orthopaedic Nursing Education Day sponsored by the Toronto Area Interest Group of the Orthopaedic Nurses Association. To be held on Feb. 16, 1977 in The Sheraton Centre, Toronto, Ontario. For information contact: *Heather Reuber, 392 Paisley Blvd. West, Mississauga, Ontario.*

Motivation for Nurses a conference to be held in Calgary, Alberta on Feb. 17-18, 1977. For information contact: *Division of Continuing Education, University of Calgary, Calgary, Alberta, T2N 1N4.*

Communicating through Objectives — a one-day conference for management and supervisory staff to be held Feb. 8 in Toronto, Ont.; March 8 in Montreal, P.Q.; and March 10 in Vancouver, B.C. For information contact: *Practical Management Associates, P.O. Box 751, Woodland Hills, Ca. 91365.*

March

Recent Advances in Cardiovascular Nursing to be held on March 2-4, 1977 in Saskatoon, Saskatchewan. Fee: $45.00. For information contact: *Norma J. Fulton, Director, Continuing Nursing Education, Room 411, Ellis Hall, University of Saskatchewan, Saskatoon, S7N 0W0.*

American Operating Room Nurses 24th Annual Congress to be held on March 20-25, 1977 at Anaheim Convention Center, Anaheim, California. For information contact: *AORN Congress Department, 10170 E. Mississippi Ave., Denver, Colo. 80231.*

Audiometry and Hearing Conservation in Industry to be held on March 22-24, 1977 at the Rensselaer Polytechnic Institute, Troy, New York in cooperation with Albany Medical Center Hospital. For further information contact: *Office of Continuing Studies, Rensselaer Polytechnic Institute, Communications Center 209, Troy, New York, 12181.*

Job of Supervision — a one-day conference to be held on March 9 in Vancouver, B.C.and on March 31 in Toronto, Ont. For information contact: *Practical Management Associates, P.O. Box 751, Woodland Hills, Ca. 91365.*

April

Registered Nurses Association of Ontario Annual Convention to be held at the Royal York Hotel in Toronto, on April 28-30, 1977. For information contact: *RNAO, 33 Price St., Toronto, Ontario, M4W IZ2.*

The Nurse Administrator's Role in Implementing a Quality Assurance Program in any Health Agency. To be held on April 4-6, 1977 in Harrison Hot Springs, B.C. For information contact: *Jo-Ann Wood, Continuing Nursing Education, 1st Floor, Instructional Resources Centre, The University of British Columbia, Vancouver, B.C. V6T 1W5.*

Ninth Annual Meeting of the American Association of Neurosurgical Nurses to be held in Toronto, Ontario on April 24-28, 1977. For information, contact:*The American Association of Neurosurgical Nurses, Business Office, 428 East Preston Street, Baltimore. Md. 21202.*

National League for Nursing 25th Anniversary Convention and Exhibition to be held on April 24-27, 1977 in Anaheim, California. For information contact: *National League for Nursing, 10 Columbus Circle, New York, New York 10019.*

May

Alberta Association of Registered Nurses Annual Convention to be held on May 3-6, 1977 in Calgary, Alberta. For further information contact: *Alberta Association of Registered Nurses, 10256 — 112th St., Edmonton, Alberta, T5K 1M6.*

Manitoba Association of Registered Nurses Annual Meeting will be held at the University of Brandon, Brandon, Manitoba on May 15-17, 1977. The theme of the meeting will be related to "Standards." For information, contact: *Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg, Manitoba, R3C 0X2.*

Registered Nurses Association of British Columbia Annual Meeting to be held on May 11-13, 1977 at the University of British Columbia in Vancouver. For information contact: *RNABC, 2130 West 12th Ave., Vancouver, B.C., V6K 2N3.*

Saskatchewan Registered Nurses' Association —Sixtieth Annual Meeting to be held at the Hotel Saskatchewan, Regina, Saskatchewan on May 11-13,1977. For information contact: *Saskatchewan Registered Nurses' Association, 2066 Retallack Street, Regina, Saskatchewan, S4T 2K2*

New Brunswick Association of Registered Nurses Annual Meeting to be held May 31, June 1-2, 1977 at Campbellton, New Brunswick. For information contact: *New Brunswick Association of Registered Nurses. 231 Saunders Street, Fredericton, N.B., E3B 1N6.*

Tenth Communicating Nursing Research Conference to be held in Denver, Colorado on May 4-6, 1977 For information contact: *WICHE, Nursing Research Development Program, P.O. Drawer P, Boulder, Colorado 80302.*

Director of Labor Relations Service

Applications are invited for the newly created position of Director of Labor Relations Services at Canadian Nurses Association, Ottawa.

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Library Update

Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

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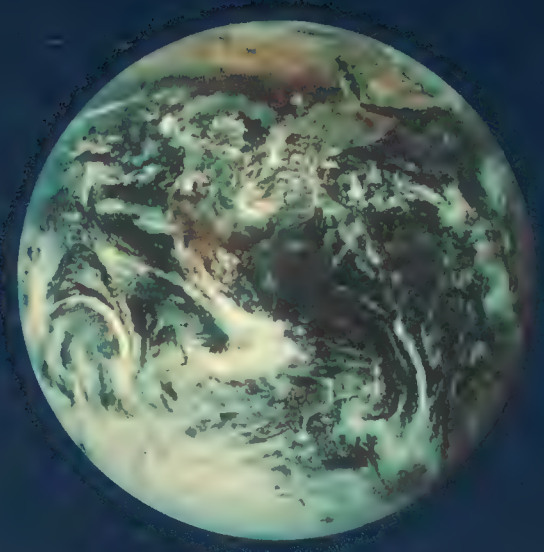
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the canadian nurse

February 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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These days, fathers are getting in on the act at every stage of the growth and development of their offspring as this month's cover photo illustrates. On page 16, author Linda Leonard, describes the reaction of some fathers to their participation in the events leading up to and including the birth of their children. Cover photo by Miller Services Limited.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

Of all the "helping professions," nurses must be among the most keenly aware of the toll that poverty exacts in terms of our vital human resources. Every day, in the people we care for, we see the effects of dietary deficiencies, under-nutrition and all the other deprivations associated with life below the poverty line. We recognize that a link exists between malnutrition and anemia, low resistance to infectious diseases, mental retardation and mental illness. We know also that the deprivations arising from a marginal existence present a special threat to certain of our patients — the very young, the old, the disabled and the expectant mother. We have read that studies of the children of the poor (Montreal, 1969) prove that half of them show signs of emotional problems and that almost one third of them exhibit symptoms of malnutrition, retarded growth (height and weight) and psycho-motor retardation.

The poor, in fact, survive in an environment that almost prohibits mental and social well-being and has an even more disastrous effect on their physical health. A representative of the Canadian Medical Association has estimated that "the 20 percent of the population that are poor suffer something like 75 to 80 percent of major illnesses."

It is now more that five years since the Senators who travelled across Canada listening to the poor and studying their submissions, tabled their report , "Poverty in Canada." In this, they acknowledged the existence in Canada of "an ugly sub-culture within society" whose inhabitants generally receive inferior educational, medical, cultural and information services and whose children, "the most helpless victims of all, find even less hope in a society whose social-welfare system from the very beginning destroys their dreams of a better life."

Since then, as the Economic Council of Canada points out, the poverty gap has widened. Between 1965 and 1974, according to the ECC, the only group to increase its share of total pre-tax income was the top 40 percent of families and individuals. The share of the *bottom* 40 per cent of families and individuals in fact *decreased* from 16.2 percent in 1965, to 14.9 percent in 1974.

When the Poverty Committee submitted its report in 1971, the principal recommendation of its members was for acceptance by Canada of the right of all of its citizens to an adequate minimum income. The Senators saw implementation of a Guaranteed Annual Income as the first and most crucial step in a comprehensive program to combat poverty in Canada in the Seventies. Political and social acceptance of the GAI would, they believed, depend on the extent to which Canadians and their elected leaders recognized some form of income maintenance as a viable alternative to the chaos of the existing welfare system.

The future of the Canadian social security system is still up in the air. A blue-ribbon task force with representatives from both the departments of Health and Welfare and Finance is currently studying possible changes in the tax system to provide a guaranteed income for the two million working Canadians who live in poverty. The proposed system could be expanded later to cover all Canadians who now depend upon the welfare system for much of their income.

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Canada's Minister of Health and Welfare has indicated that he considers some form of supplement program for the working poor and a support program for those who cannot work "inevitable." The question now is "when?" It would seem the time is ripe for this kind of fundamental and long-delayed shakeup in our approach to promoting the health and well-being of our fellow-Canadians.

— M.A.H.

Herein



How long is it since you made your first hesitant attempts to apply the nursing skills you had learned in a classroom to the care of your "very own patient?" Every nurse has memories — some bitter, some sweet — about her first real patient. We think that, no matter how long it's been, Heather Sproul's story about Mrs. B. will strike a familiar chord for all our readers.

In our society, the victim of a rape is often the victim of bureaucratic, unfeeling medical and judicial systems as well. In hospitals, the treatment given to a woman who has been raped often leaves a great deal to be desired, especially in the area of emotional care. This month, **Care of the Rape Victim in Emergency** on page 42 provides some guidelines for those nurses who deal with rape victims.

Is the fetal monitor an expensive and risky toy, or a means of reducing North America's alarmingly high perinatal mortality figures? **Next month,** author Ellen Hodnett investigates what researchers have to say about the use of fetal monitors in assessing fetal health just prior to delivery.

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Appropriate clinical content

I share the conviction, stated in the last paragraph of "Perspective," (October, 1976), that to be professional we need a special body of knowledge and skills that only members of our occupational group possess. Because nursing is a practice discipline, it follows that the development and communication of appropriate clinical content is a mandatory activity for nurses. I therefore expected you to request clinical articles on the etiology, incidence, signs, symptoms and treatment of phenomena which nursing practitioners manage independent of other disciplines.

However you request articles that derive from a medical rather than a nursing classification scheme, i.e. cancer, arthritis, dermatology. Most of the data you solicit, i.e., etiology, incidence, signs and symptoms of a disease, are already available in medical journals. A simpler version of that knowledge is contained in the journals for persons working in the physician's assistant role.

Thus I must ask: What are your criteria for classification of a clinical nursing article? Would you be interested in receiving *clinical articles that deal with nursing diagnoses that reflect patient situations* that arise because the person has a disease state but that do not use a medical classification scheme for identification? For instance, I do work with patients who have cancer. I need an understanding of this disease process as it relates to my patients' coping with both the disease and the medical regimen. My major skills and knowledge as a nurse focus on helping these persons and their families to: manage their fears of death; adapt to changes in body image that come from treatment and disease progression; and manage the experience of pain and changes in their activities of daily living that ensue. Persons who have the disease label called 'cancer' may experience any or all of these phenomena but so will patients suffering from other diseases. My understanding of these phenomena comes from the research and theory of many disciplines and articles on these nursing concerns and cannot be discussed under categories such as the 'dermatology patient.'

I also consider the management of client situations in which there is no disease state present appropriate clinical content for the discipline of nursing. Would articles on this topic be included or excluded in your inventory?

— Jessie Mantle, R.N., London, Ontario.

The editor replies:

Our request for clinical articles based on a medical classification scheme is largely an historical accident: the most common complaint we receive about deficiencies in editorial content is the absence of "clinical articles like the ones in the American nursing journals." In our attempt to analyse the journal over the past five years in response to this criticism, we grouped published articles according to disease states.

There was no intent to "put down" nursing diagnoses. We do feel, however, that in order to be complete, a clinical article should provide nurses with enough information about the pertinent etiology, incidence, signs, symptoms etc. of a disease state to serve as a handy review. Our feeling is that this knowledge is useful in developing the larger concerns that you mention — such as helping patients and their families to adjust, adapt, manage etc.

— M.A.H., Editor.

Essential or non-essential?

As a Public Health Nurse I am experiencing anger and frustration. For years we have been docile handmaidens, reluctant to speak out against those changes that seem to have caused only deterioration in the health field. I feel our government and our communities need to be educated about our role as public health nurses in a growing society. Health care costs have increased; too often I have been told that the reason lies in the high salaries of registered nurses.

If public health nursing were used to its fullest potential, it could definitely reduce the cost of health care. I have read that those employed at the Liquor Control Board are classified as providing "essential services"; public health nurses are not.

As members of a community, preventive medicine should be foremost in our minds. The public health nurse functions as a coordinator, counsellor, nurse, and teacher of health-related topics. We are involved with every age group, in the schools, homes, hospitals and places, of employment.

If our doctors utilized our services, many of the patients that arrive in their offices could be seen by a public health nurse. If, after she assessed the situation, she felt a doctor should be consulted, then a referral would be made. Immunization should be looked after by the health agencies, not by a doctor who should be utilizing his time in a different manner. Mothers should be encouraged by the doctors to contact the public health nurse if they are concerned about feeding and care of a child. If the problem is one that requires the doctor's expertise, then an appointment could be made to have the child seen. Family planning and birth control clinics should be well attended — why should a gynecologist see patients who could be taught at these clinics?

A comment has been made that we are too highly specialized for what we do. My reply to that comment is — since we are well trained to cope as members of the health team, then direct added responsibilities towards public health nurses rather than to a highly paid, overworked group.

— Mrs. Vi Krmpotich, R.N., P.H.N., Sault Ste. Marie, Ontario.

Curing career cramp

As a group, nurses now have considerable security and a trend toward complacency is understandable. We have achieved considerable gains in terms of remuneration but from a personal or a professional standpoint, a monetary definition of success isn't quite sufficient. Success is almost impossible to define but a working answer would be that we are a success as individuals and as a profession if we get to do what we perceive to be our work. This would seem to involve determining what our work is, but need not be a once-and-for-all decision: the many roles of nursing are still evolving.

Following the Boudreau Committee report there was animated discussion of this point. Almost every issue of *The Canadian Nurse* carried reports of pilot projects where nurses were attempting new patterns of practice. It's fashionable today to say that nurses are overpaid, but the other side of that statement is that nurses are underutilized. Yet, the basis for professional expansion has been afforded us in the flexibility evident in deciding what responsibilities for patients a nurse may undertake.

Pilot projects are clearly necessary, but often when the novelty wears off one feels that the new range of practice is confined to the area where the pilot project was undertaken. It has not spread to other areas or institutions. Of course there is conflict inherent in what must be done for the patient — how it should be done and by whom. The old hierarchical values tell us conflict must be avoided at all costs, and yet conflict can be productive and even fun. In any case, it's not possible to eliminate it entirely from organizations. Attempts to avoid it block our development and lead to career cramp. The Pickering Report indicates that the public are affording us the chance to enlarge our practice.

We cannot expect to continue doing things in the old familiar way. What is needed now is that each nurse deliberately attempts to improve and expand her own performance to fill the void between expensive medical care and those patient needs that can be handled by the nurse. This grass roots effort seems one way of increasing our productivity and testing our ability and acceptability. The present level of our remuneration carries a responsibility to demonstrate our increased worth to our employers and the community.

— Gabrielle Monaghan, R.N., Belleville, Ontario.

Wrong subject!

Notice of my dissertation was published in the December issue of the journal. My name was recorded as Haliburton, John C.

John Haliburton is my cousin and is currently doing research on changing manure to gas at the University of Manitoba, Winnipeg.

My topic is evaluation of the new curriculum in the nursing school. Would you please make the appropriate corrections.

— Jane C. Haliburton, Ed. D., Director of Education, Yarmouth Regional Hospital, Yarmouth, N.S.

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By Sue Rodwell Williams, M.P.H., M.R.Ed., Chief, Nutrition Program, Kaiser-Permanente Medical Center, Oakland, California; Instructor, Human Nutrition, Chabot College, Hayward, California; Field Faculty, M.P.H.—Dietetic Internship Program and Coordinated Undergraduate Program in Dietetics, University of California, Berkeley, Calif. March, 1977. 3rd edition, approx. 720 pages, 7" x 10", 134 illustrations, including original drawings by George Strauss. About $13.40.

New 3rd Edition! NUTRITION AND DIET THERAPY: A Learning Guide for Students. By Sue Rodwell Williams, M.P.H., M.R.Ed. March, 1977. Approx. 196 pages, 7 1/4" x 10 1/2", 1 illustration. About $7.10.

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Thoroughly updated and revised, the new edition of this popular text continues to offer comprehensive coverage of the basic principles of microbiology. Authoritative and well-written discussions explore: essential concepts, procedures for study, production of infection; preclusion of disease; pathogens and parasites; and public welfare. Students will especially appreciate the clear presentation of laboratory methods, rules for specimen collection, and review exercises. This new edition features a revised section on cancer; and expanded sections on tuberculosis, hepatitis, antibiotics, and allergies. Other highlights include the newest procedures for cellular immunity, the most recent information on purification of sewage, and revision of the tables on immunization requirements. Thirty-four new illustrations and eleven new tables have been added.

By Alice Lorraine Smith, A.B., M.D., F.C.A.P., F.A.C.P., Professor of Pathology, The University of Texas Health Science Center at Dallas, Texas; formerly Assistant Professor of Microbiology, Department of Nursing, Dominican College and St. Joseph's Hospital, Houston, Texas. April, 1977. 8th edition, approx. 736 pages, 7" x 10", 341 illustrations. About $15.70.

New 4th Edition! MICROBIOLOGY LABORATORY MANUAL AND WORKBOOK. By Alice Lorraine Smith, A.B., M.D., F.C.A.P., F.A.C.P. April, 1977. Approx. 192 pages, 7 1/2" x 10 1/2", 46 illustrations. About $7.25.

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Calendar

March

Call for Research Papers for Workshop on Research Methodology in Nursing Care to be held in Ottawa, Ontario, on 9, 10, 11 November 1977. Workshop theme: Management of methodological problems encountered in research in nursing care. Attendance by invitation. Papers which describe methodological problems encountered are invited from nurses conducting research in nursing care. Initial inquiries regarding preparation of papers accepted until 15 March 1977; completed submissions must be postmarked not later than 20 April 1977. For information contact: *Marion Kerr, Research Officer, The Canadian Nurses Association, 50 The Driveway, Ottawa, Ontario, K2P 1E2.*

Writing Workshop for Nurses to be held in Toronto on March 3-4, 1977. Fee: $50. Contact: *Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, 50 St. George Street, Toronto, Ontario, M5S IAI.*

The Nurse Practitioners' Association of Ontario Annual Workshop to be held at the Sunnybrook Medical Centre, Toronto on March 10 and at McMaster University, Hamilton on March 11, 1977. For information contact: *Megan McCullough, 32 Chelvin Drive, Georgetown, Ontario L7G 4P9.*

Budgeting for the Head Nurse and Coordinator to be held March 14, 1977 in Calgary. Fee: $20. Contact: The Division of Continuing Education, University of Calgary, Calgary, Alberta, T2N 1N4.

Nursing Assessment: Keystone to Care Planning to be held March 23-25 , 1977 in Calgary, Alberta. Fee: $51. For information contact: *The Division of Continuing Education, University of Calgary, Calgary, Alberta, T2N 1N4.*

Annual Meeting of the Canadian Nurses Association, 31 March 1977, Ottawa. Contact: *The Canadian Nurses Association, 50 The Driveway, Ottawa, Ont., K2P 1E2.*

April

Registered Nurses Association of Ontario Annual Convention to be held at the Royal York Hotel in Toronto, on April 28-30, 1977. For information contact: *RNAO, 33 Price St., Toronto, Ontario, M4W IZ2.*

Interviewing for Nurses to be held April 4-6, 1977 in Lethbridge, Alberta. Fee: $55. Contact: *Division of Continuing Education, University of Calgary, Calgary, Alberta, T2N 1N4.*

Leadership in Nursing, to be held April 13-15, 1977 in Lethbridge, Alberta. Fee:$55. Contact: *Division of Continuing Education, University of Calgary, Calgary, Alberta, T2N 1N4.*

Symposium on Coping with Cancer to be held at the Royal York Hotel, Toronto, Ontario on April 24-26, 1977. Topics to be discussed include: cancer prevention, screening for cancer, helping the newly diagnosed patient, palliative care and other related topics. *Contact your provincial nurses' association for details and registration forms.*

The Director of Nursing and Clinical Nursing Research, to be held in Toronto on April 21-22, 1977. Fee: $50. Contact: *Dorothy Brooks, Chairman, Continuing Education Programme, Faculty of Nursing, 50 St. George Street, Toronto, Ontario, M5S IAI.*

May

Twenty-Second Annual Convention of the American College of Nurse-Midwives to be held May 2-4, 1977 at New York City's Statler Hilton Hotel. For information contact: *American College of Nurse Midwives, 100 Vermont Avenue, N.W., Suite 1210, Washington, D.C.*

Cardiology '77 — Fourth Annual Seminar on Advanced Intensive Cardiac Care to be held on May 16-18, 1977 at the Park Plaza Hotel, Toronto, Ontario. For information, contact: *Conference and Seminar Services, Humber College of Applied Arts and Technology, Box 1900, Rexdale, Ontario M9W 5L7.*

Eleventh Annual Symposium on Intrauterine Development and Fetal Management to be held on May 5-7, 1977 at the Cross Keys Inn, Baltimore, Maryland. For information, write: *Dr. John W.C. Johnson, Dept. of Gynecology and Obstetrics, The Johns Hopkins Hospital, Baltimore, Maryland 21205.*

Alberta Association of Registered Nurses Annual Convention to be held on May 3-6, 1977 in Calgary, Alberta. For further information contact: *Alberta Association of Registered Nurses, 10256 — 112th St., Edmonton, Alberta, T5K 1M6.*

Manitoba Association of Registered Nurses Annual Meeting will be held at the University of Brandon, Brandon, Manitoba on May 15-17, 1977. The theme of the meeting will be related to "Standards." For information, contact: *Manitoba Association of Registered Nurses, 647 Broadway, Winnipeg, Manitoba, R3C 0X2.*

Registered Nurses Association of British Columbia Annual Meeting to be held on May 11-13, 1977 at the University of British Columbia in Vancouver. For information contact: *RNABC, 2130 West 12th Ave., Vancouver, B.C., V6K 2N3.*

Saskatchewan Registered Nurses Association —Sixtieth Annual Meeting to be held at the Hotel Saskatchewan, Regina, Saskatchewan on May 11-13,1977. For information contact: *Saskatchewan Registered Nurses Association, 2066 Retallack Street, Regina, Saskatchewan, S4T 2K2.*

New Brunswick Association of Registered Nurses Annual Meeting to be held May 31, June 1-2, 1977 at Campbellton, New Brunswick. For information contact: *New Brunswick Association of Registered Nurses, 231 Saunders Street, Fredericton, N.B., E3B 1N6.*

Cancer Nursing Update - 1977. Progress, Problems and Prospects to be held in St. Louis, Missouri on May 9 - 10, 1977. For information, contact: *Sidney L. Arje, M.D., The American Cancer Society, 777 Third Avenue, New York, 10017.*

June

Registered Nurses Association of Nova Scotia Sixty-Eighth Annual Meeting to be held at the Isle Royale Hotel, Sydney, Cape Breton, on June 23-24, 1977. Theme: Crisis in Care. For information contact: *Frances M. Moss, 6035 Coburg Road, Halifax, N.S. B3H 1Y8.*

Fifth Canadian Regional Conference of the International Childbirth Education Association sponsored by the Edmonton Childbirth Education Association on June 28-30, 1977. Theme: Nurturing the Family. Participants include Ashley Montagu. For further information contact: *Mrs. Pat Walker, Information Officer, ECEA, 15 Glacier Crescent, Sherwood Park, Alberta, T8A 2YI.*

8th Annual Meeting of the Canadian Association of Neurological and Neurosurgical Nurses to be held at the Loews Concorde Hotel in Quebec City on June 14-16, 1977. Contact: *Ms. Beth Cook, 59 Warren Road, Toronto, Ontario. M4V 2R9.*

Annual Meeting of the Canadian Society of Allergy and Clinical Immunology to be held in Hamilton, Ontario on June 16-18, 1977. For information contact: *Executive Secretary, Canadian Society of Allergy and Clinical Immunology, 1390 Sherbrooke Street West, Montreal, Quebec.*

1977 Annual Canadian Physiotherapy Congress to be held on June 10-20, 1977 at the Edmonton Plaza Hotel, Edmonton, Alberta. For information, write: *Yvette D. Claveau, Publicity Chairman, 1977 C.P.A. Congress, 5507 — 115th Street, Edmonton, Alberta T6H 3P4.*

Multi-Disciplinary Burn Management Seminar to be held at the Misericordia Hospital in Edmonton, Alberta on June 19-20, 1977. For further information contact: *Mr. Ken Mark, Director, Rehabilitation Medicine, Misericordia Hospital, 16940 — 87th Avenue, Edmonton, Alberta T5R 4H5.*

CRITICAL CARE

2nd Edition! **DECISION MAKING IN THE CORONARY CARE UNIT.** *By William P. Hamilton, M.D. and Mary Ann Lavin, R.N., M.S.N., M.S.(H.S.A.)* This important 2nd edition can help you prepare students to make necessary decisions in the CCU. General principles and practical techniques for care of patients with cardiac pain, irregular pulse, and low blood pressure are carefully described. Actual coronary care situations illustrate each problem—providing relevant clinical experience. A new chapter discusses patient education. 1976, 168 pp., 126 illus. **Price, $7.10.**

2nd Edition! **A COMMONSENSE APPROACH TO CORONARY CARE: A Program.** *By Marielle Ortiz Vinsant, R.N., B.S.; Martha I. Spence, R.N., B.S., M.N.; and Dianne Chapell Hagen, R.N., B.S.* This programmed book reviews all major problems associated with acute myocardial infarction. New material discusses hemodynamic monitoring and drug therapy for shock and heart failure. 1975, 244 pp., 439 illus. **Price, $8.35.**

New 2nd Edition! **HIGH RISK NEWBORN INFANTS: The Basis for Intensive Nursing Care.** *By Sheldon B. Korones, M.D.* This important new edition can inform your students of the most up-to-date advances in perinatal medicine and nursing care of the high-risk infant. Explaining the "why's" behind many specific procedures, Dr. Korones emphasizes an understanding of intrauterine antecedents. A new chapter on thermoregulation adds to the value of the revision. June, 1976. 280 pp., 113 illus. **Price, $11.50.**

MATERNAL/CHILD

A New Book! **PEDIATRIC NEUROLOGIC NURSING.** *By Barbara Lang Conway, R.N., M.N.* This new text can alert students to the signs of pediatric neurologic abnormalities. It first presents a clear account of neurologic physiology; then offers informative discussions on normal neurologic development; and assessment techniques for testing children with learning disabilities, emotional disturbances, and hyperkinesis. February, 1977. Approx. 416 pp., 102 illus. **About $15.25.**

A New Book! **MATERNAL-INFANT BONDING: The Impact of Early Separation or Loss on Family Development.** *By Marshall H. Klaus, M.D. and John H. Kennell, M.D.; with 3 contributors and 8 critical commentators.* This timely book focuses on the earliest physical and sensory relationship a baby develops with his parents; the factors that enhance or inhibit this process; and the effects of this relationship on the growth of the family. August, 1976. 275 pp., 49 illus. **Price, $9.40 (H); $6.60 (P).**

2nd Edition! **THE PEDIATRIC NURSE PRACTITIONER: Guidelines for Practice.** *By Fernando J. deCastro, M.D., M.P.H., F.A.A.P., F.A.P.H.A.; Ursula T. Rolfe, M.D., F.A.A.P.,; and Janice Kocur Drew, R.N., B.S., P.N.P.; with 3 contributors.* Provide your students with a current guide to ambulatory pediatrics with the help of this text. Discussions examine the entire process of assessment and treatment, including many specific clinical problems. Some of the new material covers hematology, neonatology, parasitology, and school health. 1976, 220 pp., 8 illus. **Price, $6.85.**

A New Book! **ASSESSMENT AND MANAGEMENT OF DEVELOPMENTAL CHANGES IN CHILDREN.** *By Marcene L. Erickson, R.N., B.S.N., M.N.* This well illustrated new book provides a systematic approach to developmental screening and assessment of infants and pre-school children. It carefully shows how to use many specific assessment tools and how to plan the management of behavioral problems caused by developmental changes. July, 1976. 280 pp., 161 illus. **Price, $8.95.**

New 2nd Edition! **FAMILY PLANNING EDUCATION.** *By Charles William Hubbard, M.P.H., M.A.* The new 2nd edition of this popular book offers a concise presentation of four areas of sexuality: contraception, abortion, sterilization and venereal disease. It features a new chapter on psychosocial aspects of birth control and new information on risk factors of various contraceptive methods, counseling, and the "new" venereal diseases. January, 1977. 258 pp., 47 illus. **Price $6.25.**

News

Drug ad watchdog assumes responsibility

Canada has become one of the first countries in the western world to introduce a preclearance program for pharmaceutical advertising directed towards the health professions. The newly created Pharmaceutical Advertising Advisory Board (PAAB) which will coordinate the program was federally incorporated as a non-profit organization in January 1976. The Board brings together representatives from the health professions of medicine and pharmacy, the Association of Medical Media, the Canadian Advertising Advisory Board, the Consumers Association of Canada and the pharmaceutical industry. The Board's functions will include the preclearance of advertising of pharmaceuticals, the establishment of criteria for the approval of proposed advertising and the administration of program policy.



The permanent Chairman of the advertising preclearance program is Dr. I.W.D. Henderson FRCS(C). Dr. Henderson is a Fellow of the Royal College of Surgeons (Canada) and a widely-known specialist in clinical pharmacology in Canada. He is presently chairman of Clinical Research and also of the Pharmacy and Therapeutics Committee at the Ottawa General Hospital, and associate professor in the Department of Surgery and Pharmacology at the Faculty of Medicine, University of Ottawa. He also serves as a consultant to the Health Protection Branch of Health and Welfare Canada and is a member of the Advisory Committee on Proprietary and Patent Medicines. Dr. Henderson is current chairman of the Canadian Medical Association Sub-Committee on Pharmacotherapy, and represents both CMA and L'Association des médecins de langue française du Canada on the Steering Committee for the proposed Canadian Drug Formulary Service.

He replaces Ley Smith, president of The UpJohn Company of Canada who served as interim chairman during the formative stages of the Board and guided the development of the advertising preclearance program.



A.V. Raison assumes the position of Commissioner of Pharmaceutical Advertising. He will be responsible for the review of submitted advertising according to a Code of Advertising Acceptance established by the Board. A panel of recognized experts from the health disciplines across Canada will advise the Commissioner on technical questions and arbitrate in cases of differing opinion. Raison takes on this position following over 15 years as editor for the periodicals of the Canadian Pharmaceutical Association.

The program, which became effective in January 1977, will initially apply only to prescription drug advertising, the bulk of which appears in trade journals. Eventually the PAAB hopes to extend its jurisdiction to over-the-counter drug advertising which comprises approximately 25 percent of drug advertising in journals. Since the Canadian Advertising Advisory Board along with the Health Protection Branch of Health and Welfare Canada reviews the advertising of over-the-counter proprietary medicines, the PAAB will *not* become involved in drug advertising that is directed to the public via radio, television or popular magazines. Its prime aim is to "ensure that the content of prescription drug advertising to the health professions continues to serve the ultimate interests of the patient."

Since the program is not mandatory, its success hinges jointly on the cooperation of pharmaceutical manufacturers to submit proposed advertising copy to the Commissioner for approval and upon the trade and professional media to accept only approved advertisements. The final responsibility for publication rests with the media. The cooperation of the health professions and other advertisers in referring enquiries and complaints to the Commissioner is also vital.

Initial funding of the program was provided by the pharmaceutical industry, the professions of medicine and pharmacy and the trade and professional media. Preclearance fees for full disclosure, reminder and institutional advertisements will be charged to advertisers to finance the continuing operation of the program.

Implementation of the program will commence with the preclearance of an estimated 300 to 400 new journal advertisements in both languages, annually. After several months, other forms of communication will be phased in. Preclearance will require a maximum of 30 days.

Better qualified personnel would benefit aged

The quality of life for the aged, in institutions and in the home, could be improved if those who care for them were properly prepared, according to the Nova Scotia Association of Registered Nurses. "The practice of permitting personal care workers to perform beyond their preparation is unsafe for the aged and represents a legal hazard for both employer and employee."

The warning is contained in a position paper "Personnel Required to Meet the Needs of the Aged," issued by the Registered Nurses Association of Nova Scotia as part of a continuing program to improve care of the aged in that province.

The paper, prepared by a special committee appointed by the RNANS Executive, observes that, if aged persons have health problems which necessitate nursing care, whether in their own home, or in an institution, this care should be given by registered nurses or certified nursing assistants. While recognizing that there are many needs of the aged which can be met by homemakers and/or personal care workers, the RNANS is concerned about the varying quality of courses to prepare this type of personnel and the proliferation of uncoordinated training programs.

As a result of these concerns, the Registered Nurses Association believes that there is a need for the appointment of an individual or a group to study the need for homemaker services for the aged, and that there should be collaboration with existing services to develop a coordinated plan, organized on a regional basis, with regional directors.

Guidelines for Homemakers for the Aged and for Personal Care Workers, are included with the Position Paper.

Did you know...

- 40% of Canadian men and 47% of Canadian women have fitness levels classified as fair or low.
- Canadian women, with teenage and 20-29 year olds rated the lowes are less fit than men.
- Cardiovascular fitness declines steadily from the age of 8, stabilizin at a very low level, only in late adolescence.
- Over half of the adult Canadia population is overweight, and those who are fat eat the same number c calories as those of normal weight.
- 40% of Canadians watch more than 15 hours of TV every week.
- Only 20% of Canadians engag in some form of physical activity su as walking for pleasure, jogging, hiking or other exercise.
- Canada's medical care bill increased from 2 billion dollars in 19 to more than 7 billion dollars now — rise of some 14% per year.

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PHARMACOLOGY

New 6th Edition! BASIC PHARMACOLOGY FOR NURSES. *By Jessie E. Squire, R.N., B.A., M.Ed. and Jean M. Welch, R.N., A.B., M.A., B.S.N.ed.* Updated to include the most current drug data available, this vocational nursing text presents basic information on drug administration, source, purpose, route, side effects and contraindications. New information includes intravenous therapy, physiology, techniques and nursing responsibilities. April, 1977. Approx. 360 pp., 58 illus. **About $7.30.**

A New Book! CALCULATING DRUG DOSAGES: **A Workbook.** *By Ruth K. Radcliff, R.N., M.S. and Sheila J. Ogden, R.N., B.S.* This new workbook can help students learn the necessary math to safely and accurately calculate drug dosages. After a pretest to determine each student's needs, the text discusses general mathematics and all the essentials required for dosage calculation. January, 1977. Approx. 224 pp. **About $8.35.**

13th Edition. PHARMACOLOGY IN NURSING. *By Betty S. Bergersen, R.N., M.S., Ed.D.; in consultation with Andres Goth, M.D.* Written by a nurse for nurses, this leading text outlines current concepts of pharmacology in relation to clinical patient care. It features comprehensive, well-organized discussions on drug action, indications, side effects, toxicity, and safe therapeutic dosage range. Two new chapters explain antimicrobial agents and drug effects on sexuality and fetal development. 1976, 766 pp., 100 illus. **Price, $14.20.**

A New Book! HANDBOOK OF PRACTICAL PHARMACOLOGY. *By Sheila A. Ryan, R.N., M.S.N. and Bruce D. Clayton, B.S., Pharm.D.* This practical handbook conveniently summarizes dosage, action, usage, possible side effects and interactions of more than 80 commonly used single-entity drugs. Categorized according to their primary action, drugs are arranged alphabetically by generic name within each chapter, and indexed at the end of the book. January, 1977. 252 pp., 2 illus. **Price, $7.30.**

FUNDAMENTALS

2nd Edition! THE COMPOSITION AND FUNCTION OF BODY FLUIDS. *By Shirley R. Burke, B.S.N., M.S.N.Ed.* This new edition can provide students with a sound understanding of general principles of body fluids. Examining the relationship of body fluids to health and the consequences of typical defects in the regulatory system, the text carefully explains cell function, extracellular fluid, fluid balance, and acid-base balance. A new chapter on blood clotting adds to the value of this revision. 1976. 128 pp., 21 illus. **Price, $5.25.**

New 2nd Edition! BODY FLUIDS AND ELECTROLYTES: **A Programmed Presentation.** *By Norma Jean Weldy, R.N., B.S., M.S.* Using a step-by-step approach, this practical self- teaching manual presents basic principles of normal body fluids and electrolytes, common abnormalities, and clinical applications. The section on "Electrolyte Imbalance" has been considerably revised with new material on potassium imbalance and new, updated questions. Summaries and review questions conclude each chapter. March, 1976. 130 pp., 24 illus. **Price, $5.80.**

A New Book! NURSE-CLIENT INTERACTION: **Implementing the Nursing Process.** *By Sandra J. Sundeen, R.N., M.S.; Gail Wiscarz Stuart, R.N., M.S.; Elizabeth DeSalvo Rankin, R.N., M.S.; and Sylvia Parrino Cohen, R.N., M.S.* Emphasizing the importance of interpersonal communication, this unique text presents psychodynamic and sociological principles relevant to the nursing process—the emergence of the self, the helping relationship, stress, etc. April, 1976. 214 pp., 38 illus. **Price, $7.90.**



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News

Nurse to direct Information Centre at Hospital for Sick Children

A plan now in the finalization stage for a Medical Information Centre for the Hospital for Sick Children in Toronto is a comprehensive attempt to answer many common public and in-hospital needs. The new department will provide services in an organized way, services including triage, poison information, channels for medical consultation, public advisory information, and family physician feedback.

Gail Funger, an experienced nursing instructor in the Emergency department at HSC, will direct the Medical Information Centre in these functions. She explains that most of these needs have been met in the past in a haphazard way, that people requiring information quickly had to make many calls or visit many departments before reaching the appropriate source of help. She also explains specifically what the services offered by the new department will mean to those that require them:

- **Triage** — Triage is defined as sorting out or setting priorities, and refers to the placement of patients arriving at the Medical Information Centre without an appointment. The patient will see an experienced nurse at the centre, who will judge whether he should be seen in emergency or in one of the out-patient clinics. The patient and his parents can receive the attention and support of the nurse, and the delay and anxiety inherent in wandering from one department to another is avoided. The nurse's decision regarding placement will be final. No patient she directs to emergency will be rerouted back to out-patients, causing delay and anxiety for the patient and his parents.
- **Poison Information** — Establishment of the Medical Information Centre at HSC will allow calls for poison information to be referred directly to specially trained nurses (with a medical backup consultant) who are prepared to handle difficult calls. HSC has Canada's largest poison information center. The establishment of the Medical Information Centre will make related information more directly available, and will free emergency staff to care for their patients.
- **Medical Consulting Services** — Community doctors requiring specialty consults will be able to call the Medical Information Centre. The nurses there will be knowledgable in fielding such calls to the appropriate HSC consultant.
- **Public Advisory Service** — Many calls to the emergency department at HSC are from concerned parents who want to know from a reliable source how to care for their sick child. Nurses at the centre will be able to answer public enquiries or to refer the callers directly to a qualified person, avoiding an unnecessary and anxiety-provoking delay for the parent in receiving information. This service will also relieve some of the pressure on the emergency department and ensure follow-up of the patient and parents.
- **Family Physician Feedback** — Staff in the Centre will ensure that contact is made with a patient's family physician if he is admitted to HSC from the emergency department.

The Medical Information Centre is expected to open this Spring, and will be located just inside the Gerrard Emergency Entrance.

UNB announces changes in nursing program

The University of New Brunswick has announced curriculum changes in its three-year baccalaureate program for nursing students. The changes according to Carolyn Pepler, associate professor of nursing and curriculum chairman for the faculty of nursing, are in line with evolving circumstances of modern health care.

"The first change is an emphasis on promoting health as opposed to treating illness", she said. Education in the health sciences traditionally centered on the study of symptoms and treatment of known diseases. The new curriculum stresses the nurse's role in promoting healthy lifestyles and preventing illness, she pointed out.

The second alteration in the curriculum is a switch from the study of nursing as it relates to locale and/or medical specialty to a focus on the nursing functions in any setting. This means that instead of talking about surgical nursing, public health nursing or psychiatric nursing, they will talk more about the nurse's work of comforting, preventing trauma, providing therapy, counselling, and so forth, says Prof. Pepler.

The third modification is an increased emphasis on the problem-solving approach to nursing and learning. Since the modern nurse deals more with complex situations than clearly-defined diseases and cures, she will have to be flexible and innovative in her approach.

During their first year the students will be looking at themselves and those around them to develop their skills in observation and data collection. They will attempt to modify their own health habits and will be studying the theory of change in that context.

In their interactions with patients, the first year students will concentrate on the comforting and protecting functions of the nurse, under the new program.

The new curriculum will be expanded year by year as this year's freshmen move through their program. Prof. Pepler pointed out that though they will not participate in the complete new program, the current upper classes in the nursing faculty are being exposed to many of the underlying concepts and some of the classwork.

In the second year the students will expand their nursing to include the therapeutic role and the role of the health teacher, and will begin to give attention to the patient's family, she said.

The third year program, building on a coursework foundation, will involve the students in more teaching and counselling.

In their final year, the nursing students will develop the role of the nurse as collaborator and advocate. The collaborative situation is one in which the nurse may have the primary contact with the patient, and works with doctors, other health agencies and with social agencies for the patient's care and welfare.

Health happenings

More than 100 babies with congenital malformations are born each year in Canada as a result of their mothers developing rubella during the first three months of pregnancy.

Despite the availability of effective vaccines, **infectious diseases** are still among the four leading causes of hospitalization among children. "Parents tend to think that communicable diseases are a thing of the past and neglect to immunize their children," according to child health consultant, Shirley Post in an article in the December issue of *Canadian Consumer*. Dr. Post points out that Canadian children spent a total of almost 500,000 days in hospital in 1971 (latest available figures) as a result of infectious diseases. See also, "Communicable Diseases and Immunization" by L. Cranston, *The Canadian Nurse*, January, 1976.

A paper entitled "Living with the dying: use of the technique of participant observation," published in the Dec. 18, 1976 issue of the *Canadian Medical Association Journal* makes interesting reading for nurses as well as members of the medical profession. One interesting sidelight is the observation of the **effects of hospitalization** on a well 31-year-old man.

M., a medical anthropologist, conducted a study to observe the kind of care given to patients in the Palliative Care Unit of the Royal Victoria Hospital in Montreal. As a pseudopatient in the Palliative Care Unit, he was surprised to find that he began to experience symptoms of illness. The study reports, "Once on the unit, he identified closely with these sick people and became weaker and more exhausted. He was anorexic and routinely refused to take a shower. He sat exhausted in a chair. He experienced increasing pain, a constant ache in his left leg together with numbness and restless nights during which family members of other patients commented sympathetically on his 'moaning and groaning.' M. himself was not aware of this nocturnal behavior."

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Nursing education may be just waking up to the fact that we live in an electronic age where students need to become involved in their education. Children raised on the instantaneous communication of television become adults who demand the experience of film rather than being the passive recipients of printed or spoken words. The Nursing Education Media Project is Ontario's answer to the need to develop greater familiarity with audiovisual aids for use in nursing education. Films such as "Don't Cry for David" attest to the fact that, although still in its infancy, the organization is gaining in confidence and creativity ...

Idea Exchange

Education in the Electronic Age

Manuel Escott

The Nursing Education Media Project (NEMP) is a unique project to educate Ontario nursing teachers in the use of audiovisual techniques and to produce and distribute audiovisual material. As such, it has attracted the interest of nursing agencies throughout Canada and the United States. The product of a decade in which visual teaching has become as important as the book or the lecture, NEMP requires the highest degree of co-operation from its participants: Ontario's 22 community colleges, the Registered Nurses Association of Ontario, the College of Nurses, and the Ontario Educational Communications Authority (OECA), the the province's award-winning public broadcasting service. Ryerson Polytechnical Institute in Toronto, and the University Nursing Programs are active observers.

NEMP costs between $45,000 and $50,000 a year to operate. The money comes from the agencies taking part.

Until a few years ago, the creation of such a project would have been difficult. Only a handful of nursing schools, mainly in the bigger cities and towns, had access to audiovisual equipment. Nor was there any overall program of instruction in its use. All of that changed when the schools were absorbed into the community college system, each of which had a media resource center.

Community college officials and health science experts assessed the situation and foresaw the danger of wasteful duplication in increased audiovisual production. They also realized that there was a lack of production expertise and that material covering many critical subjects such as obstetrical and neuropsychiatric nursing was frequently inappropriate and/or out-of-date.

Initially, a series of exploratory meetings were held to determine the feasibility of the media project and map out its structure. Marilynne Seguin, a health science media consultant and former nursing teacher, travelled throughout Ontario for six months, talking to college officials about priorities and available facilities and personnel. The result was the creation of NEMP, a multi-faceted cooperative with Ron Keast, of OECA's Media Division, as chairman.

NEMP has four basic objectives:

- to identify teaching-learning resources for nursing education;
- to produce and distribute instructional packages of audiovisual material;
- to educate nursing teachers in the use of audiovisual techniques — videotape, 16 mm film slides, editing, production;
- to distribute quality work done by one NEMP member to all other members.

Of equal importance is the ongoing evaluation of materials for college use and the identification of subjects for new productions and agencies that can assist NEMP.

NEMP holds seminars and workshops throughout the province of Ontario. These are designed to use the know-how and facilities of OECA and the college and university resource staffs, plus guest authorities in many fields, in teaching nursing educators about AV techniques. For example, workshop delegates discuss, design and produce learning packages to be evaluated in the final phase of the workshop. Any faculty with a communications problem — whether visual or print — can call in a member of the project resource team to help.

Although still very much in its infancy, NEMP appears to be gaining in confidence and creativity. Its agencies have produced dozens of works on a wide range of topics, from "Care of a patient in a Stryker Frame" to "Oral Medication." All productions — videotapes or slide tapes with written material — are distributed to colleges through OECA.

The project's most ambitious effort to date is "Grieving Due to Loss of Body Image: Don't Cry for David," a two-part videotape on the rehabilitation of a young athlete whose leg is amputated. The tape is accompanied by two learning activity packages that include print material, slides and audiotapes.

Eight pilots, the first of a series of over 20 presentations on ethics, and a series on law, are in the planning stage. According to Marilynne Seguin, both the law and the ethics series are in response to a demand by nursing faculties. The productions are designed to illustrate problems rather than to answer all questions. Seguin says that the problems find resolution through discussions following the production.

Another major production — "Charge: Incompetence, a Mock Hearing of the Discipline Committee of the College of Nurses of Ontario" is a 68-minute videotape produced at McMaster University in Hamilton, Ontario. It enacts a disciplinary hearing based on an actual case.

"This production should be of major educational value," says Seguin. "Lawyers tell us that nurses tend to treat complaints against them lightly and sometimes don't even bother to respond to complaint notifications. Then, of course, they're shocked to find that their right to practice is jeopardized. Often, they have a very plausible explanation for their actions but have not fully communicated these factors."

The ethics series attempts to define a highly controversial area where a nurse's personal morality can conflict with the law or other authority. What patient information, for example, should remain confidential? What is the nature of a nurse's responsibility to herself, her patient and the health team on which she works? Under which circumstances can she refuse to give treatment? The series will also deal with many other issues, including euthanasia, abortion, truth and lying, and organ transplants.

How effective has NEMP been thus far? "It has a great potential, but it's a little too early to assess it fully" says Fred Habermehl, the Health Sciences Director of Niagara College, Welland. "Some of the first productions were too long, but this is changing."

"The law and ethics series will have a major impact when they're distributed. Nursing faculties find it difficult to get a handle on these subjects. The films should give us specific illustrations of the problems encountered."

"What we can say are effective, are the seminars and workshops. These are invaluable in teaching faculties how to use visual media properly."

Manuel Escott *has been a journalist for the last 24 years. A feature writer for the Toronto Star for seven years, and foreign correspondent with Reuters in the Middle East and West Africa, Escott has been a freelance writer since 1972.*

Recent emphasis on family-centered maternity care is a step in the direction of recognizing the father's role in childbirth. Because he has been neglected for so long little is known about his feelings during the experience. This review of a study of husbands' perceptions of labor and delivery, and their reactions to nursing care draws important implications for the prenatal preparation of couples and for their care within the hospital.



The father's side

a different PERSPECTIVE on childbirth

Linda Leonard

Since the advent of modern health care the husband-father has received little attention during the childbirth phase of the life cycle. Although he "plants the seed" and shares many experiences with the expectant mother during pregnancy, until recently he has been excluded from the event. Now, however, it seems that most husbands are present for all or a portion of the labor, and an increasing number are requesting to attend the delivery of their child.

A new emphasis in the hospital on "family-centered care" seems to indicate official acknowledgement that the husband's presence at birth and participation throughout his wife's hospitalization is valuable for the father and for the new family. Yet despite this trend we are still very ill-informed about the thoughts and feelings of this family member during the birth process. If we aspire to provide care that is truly family-centered, we must find out more about the husband's reactions and needs during his involvement in childbirth.

This article is a summary of the results of a study which focused on the reactions of 20 husband-fathers to labor and delivery. More specifically the study probed the husbands' thoughts and feelings about the experience, their perceptions of their role during labor and delivery, and their thoughts about nursing care.[1]



The Study

The study took place in a family-centered maternity unit which has approximately 1,100 births annually. Twenty Caucasian, Canadian, or British-born husbands were interviewed between 13 and 107 hours after delivery of their infant. They were between 22 and 40 years of age and had some formal education, ranging from 8 to 23 years. All attended prenatal classes and the labor, eighteen attended the birth (one father did not intend to be present, the other was unable to attend because of fatigue). Seventeen were fathers for the first time; three were fathers for the second time. All deliveries were per vagina and resulted in a healthy newborn of at least thirty-seven weeks gestation.

Interviews with husbands were conducted using an interview schedule which employed rating scales, open-end and fixed-alternative questions. No wives were present during the interviews.

The husbands responded enthusiastically to being interviewed and many began the interview with no prompting from the researcher, continuing to talk for 45 to 90 minutes.

Findings

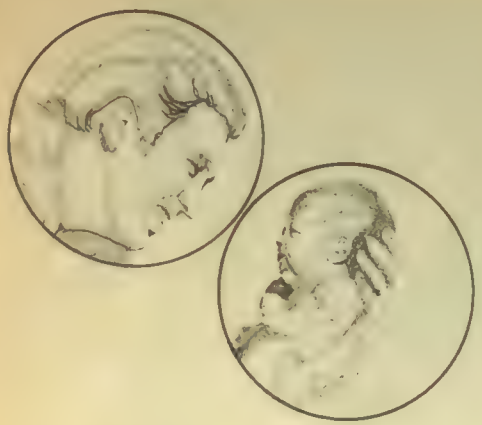
Events prior to labor and delivery

All but one of the husbands had decided to participate in childbirth by the early third trimester of pregnancy and half had made the decision before or when pregnancy was diagnosed. Only seven fathers expressed anxiety and uneasiness about attending labor and delivery, and their concerns were allayed during prenatal classes.

Most of the husbands wanted to participate because they felt their wives needed them. Typical comments were: "I wasn't going to let her go through that alone" and "It's the least I could do for her." Less popular reasons for taking part were to share the experience together and to have the opportunity to see the labor and birth.

Reactions to labor and delivery

On a rating scale ranging from +4 (excellent experience) to -4 (very bad experience) most husbands viewed labor as a slightly positive experience (mean+ I.6) and delivery as a moderately positive experience (mean + 2.26). They described the labor as "meaningful," "valuable," "a necessary evil," and viewed it as a period of helplessness for





them and a time of pain for their wives. The majority described delivery as a period of progress, a time of pain relief, and a time of exhilaration tempered with worry about possible complications for the baby.

The fact that labor was rated lower than delivery may be partially explained by exploring prevailing North American attitudes towards pain and the male role in society. The relatively passive role of the husband as protector and supporter during labor and delivery runs counter to the North American image which stresses the ability to take charge, to be in control and to solve problems.[2] His role as supporter and protector is particularly emphasized during labor because analgesics must be used judiciously. This is one time when North Americans cannot get the immediate relief from pain that they are used to seeking,[3] and for this reason the husband may feel especially helpless when he cannot see any positive results of his efforts to give encouragement and support. Thus, his effectiveness will likely influence his view of labor and his self-esteem. Delivery, on the other hand, is a period when pain-relief is offered, health team members relieve the husband of many of his functions and, finally, the sight of the emerging baby signifies the end of the laboring experience.

During the first and early second stage of labor the husbands tended to direct their emotional and intellectual energy almost solely towards their wives, noting their behavioral responses to pain, pelvic pressure and to the husbands' attempts to give support. Many tried to look for indicators that their wives were progressing in labor.

During these early stages, many husbands could not remember thinking about the baby. One father revealed "There was nothing I could do for the baby. My wife was the one who needed me." Those few husbands who indicated a high focus on the baby admitted that they were concerned about whether the baby was getting enough oxygen and whether it would be normal.

In the late second stage of labor the husband's focus changed; he was still concerned for his wife but was now caught up in the fascination of the delivery. Many admitted that it was only then that the baby became a reality. Several said that some of the delivery room procedures, such as administration of anesthesia with long needles and performance of the episiotomy, made them feel "queasy" but that they were able to overcome the feeling. The birth of the baby brought about a high focus on the infant as well as on themselves. The completeness and general health of the baby were paramount in their thoughts. They needed to know that the baby was "all there" and there were no anomalies. Reassurance that the color, cry and respirations were satisfactory was equally important, and was noted by the fathers independent of whether the baby was given a high or low Apgar rating. Few husbands made reference to their wives during this period and not one described his wife's reactions to the baby at birth.

The birth appeared to be an infinitely personal experience for the majority of the men. During the interview, some fathers were unable to find the words to describe their feeling at the time of the birth but kept struggling to do so. Several, as they recounted the birth, had tears in their eyes and noted "It was the best experience I've had in my life." A minority displayed a flat affect and related the birth and their feelings in a monotone. "I didn't feel anything," and "It was okay, I guess" are quotes from two new fathers. Another intimated that he was disappointed in his



Photos by Miller Services Limited

emotional reaction to the birth, stating that "Some people get off on seeing their child born ... I didn't." Similar experiences have been described by Greenberg and Morris.[4]

Role During Labor and Delivery

Most of the husbands saw their role during labor as that of providing support, encouragement and physical care to their wives. For this reason many chose not to leave their wives during the experience, even for rest or nourishment. Of those who did take a break, some expressed guilt at seeking this relief when their wives were unable to do so. Others noted that it was worse to be separated from their wives than to be with them.

Most felt that they had helped their wives a great deal during labor and attributed their success to the prenatal class instruction and to the labor-room nurses. At the same time they needed to confirm their success with their wives. Those who had not discussed the success of their role with their wives tended to believe that they were of very little help.

There were periods during the labor in which the husbands were not able to help their wives. They had difficulty coping with their wives' pain and loss of control during transition. Some said that they lost control and that this was precipitated by their wives' reaction to the contractions, the diagnosis of fetal distress, and/or extreme fatigue of the husband.

In a question concerning the father's right to attend the birth of his child, most felt strongly that it *was* their right. A smaller group believed that it was not their right but said they would still like to be present. The husbands spontaneously noted that if their presence in any way jeopardized the health of their wives or babies, or interfered with the health team members' performance, they would accept the decision not to be present at delivery.

Many health team members have expressed concern about husband-attendance during the birth of a sick or malformed baby. In response to a hypothetical question, nineteen fathers said they would prefer to be with their wives during the birth of a potentially unhealthy baby. They felt that they did not want their wives to be with strangers during this time and that they would be able to share their grief together.

Perceptions of Nursing Care

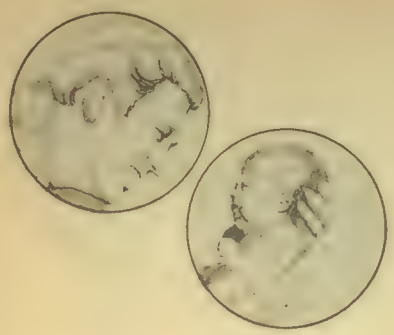
When asked what aspects of nursing care were helpful or not helpful to their wives and themselves during labor and delivery, the husbands focused on five categories:

- the attitudes and responses of the nurses
- inclusion of the husband in the experience
- assessment and explanation of labor events
- contact with the nurse other than for assessment
- physical care of the woman in labor.

The nurses' attitudes and responses which were identified as helpful were "friendly," "kind," "cheerful," "thoughtful," and "interested." Many husbands observed that the nurses cared about their wives and that the nurses' attitudes were significant in establishing their own confidence. Their perceptiveness and vulnerability during labor is illustrated by one husband's reaction to some nurses laughing outside the labor room:

> "I can appreciate that you have to laugh in a place like this but when they didn't stop... I kept looking at my wife in pain and thought 'my God, what can they find so funny?'"

Most of the husbands did not expect the nurses to go out of their way to include them in the birth experience, but when they did it seemed to leave a very positive impression. Helpful gestures of the nurses, such as



Linda Leonard *(B.Sc.N. and M.Sc.N., University of British Columbia) has worked in labor and delivery rooms and in psychiatry. She is now teaching in the Baccalaureate and Graduate programs at the University of British Columbia School of Nursing.*

bringing coffee or juice to the husband while he was at his wife's bedside and "spelling him off" for short rest periods, were seen as indicators that he was accepted by nursing staff. Husbands also appreciated the nurses' explanations and demonstrations of progress made by their wives. Several objected to being asked to leave during pelvic examinations, an observation also made by Jordan,[5] while a small number welcomed the break away from their laboring spouses.

The assessment of the mother and baby, and explanation of the results was a perceived weakness in nursing care. Husbands felt there was a need for more frequent and accurate assessment, particularly during the transition phase and the second stage of labor. Several husbands echoed the sentiments and displeasure of these three men: "I knew that she was going fast. I had to go out and get the nurses a few times... they could have anticipated how quickly she was progressing;" "There was panic at the end;" and "I could have ended up delivering the kid myself."

Husbands apparently needed to have human contact during this emotional and fatiguing experience and welcomed contact with nurses other than for assessment purposes. One husband described a nurse as exceptional:

> "She'd say that she would bring such and such in 15 or 20 minutes and then she would. You knew that you only had to go for 15 minutes, not forever, before she'd come back."

Many fathers said they knew the nurse was outside the labor room and that all they had to do was ask her to come. However, they were reluctant to summon her because, as one father stated, "She probably couldn't do anything anyway." Several fathers indicated that they saw the nurse as much as they wanted and appreciated being left "to do our own thing."

A large majority of the husbands praised the care given to their wives in the form of backrubs, assistance with position and breathing, and provision of analgesic medications and clean laundry. Problems in this aspect of nursing care centered around acquiring satisfactory pain relief for their wives.

Implications for Nursing

If nursing hopes to promote optimal family functioning, we must take responsibility for helping the husband-father to achieve satisfaction from and feel effective in his role in the birth process. The results of this study indicate some specific ways that the nurse can achieve this goal, although one must be careful in making generalizations from such a small and specific study.

The nurse involved in teaching prenatal classes should be aware that her attitude regarding husband-participation in labor and her confidence in the expectant father is highly influential. The teacher's confidence and reassurance seems to benefit those men who are undecided and uneasy about participating in labor and delivery. Husbands asked that more emphasis be placed on helping both parents cope with the pain of labor; many felt betrayed by their instructor, who left them with the impression that labor is uncomfortable but not necessarily painful. Perhaps a discussion regarding attitudes to pain as well as feelings and behaviors elicited by seeing someone else in pain would benefit husbands. It might also be appropriate to coach husbands in how to recognize behaviors that their wives indicate are emotionally and physically supportive.

The nurse caring for the couple in labor and delivery can do a great deal to make the experience a positive and satisfying one for the husband. First, she must recognize that husbands are highly sensitive during this period to the nurse's attitudes and responses to the couple. The nurse's expressions of warmth and caring, and her efforts to include the husband convey acceptance to him and foster his ability to help his wife function.

At the beginning and as labor progresses, it is important for the nurse to assess the specific role the father hopes to play in labor and delivery, as well as the kind and amount of contact the couple wants with the nurse. She must be aware that the husband is more likely to need her presence, even if he doesn't specifically request it, during the active phase of labor, during periods of ineffectual progress, and when he is tired. Permitting the husband to stay with his wife as much as the couple desires, e.g., during pelvic examinations, and being available to "spell the husband off" for rest-breaks from time to time also help to relieve the stress of the situation. To maintain the husband's confidence the nurse may also identify the ways in which the husband is being supportive of his wife. Although communicating to the couple regarding the progress of labor is a fundamental principle of care, results of the study indicate that it needs to be re-emphasized. The health status of all infants born, independent of the Apgar rating, should be interpreted to couples.

During the postpartum period it is essential that those who care for the family be alert to husband-wife-infant interaction and to their desire to communicate their reactions and feelings.[6] The nurse should encourage couples to review the labor and delivery, and their performance, as soon after delivery as possible, and to verbalize questions and concerns about the experience. This may be done with the nurse on an individual basis or she may bring together a small group of new parents to discuss their common experience.

In our recent emphasis on "family-centered care" we have begun to accept the father's role in childbirth. We still have a long way to go, however, to fully understand his needs and perceptions during this experience. This study of fathers' perceptions of labor and delivery, while taken from a small sample, offers nurses some insight into how they can help the expectant and new father. Whatever specific actions the nurse takes to convey her acceptance, care and support to the expectant father, it is clear that this neglected family member needs to be given much more attention to make the experience of childbirth as rewarding and positive as it can be.

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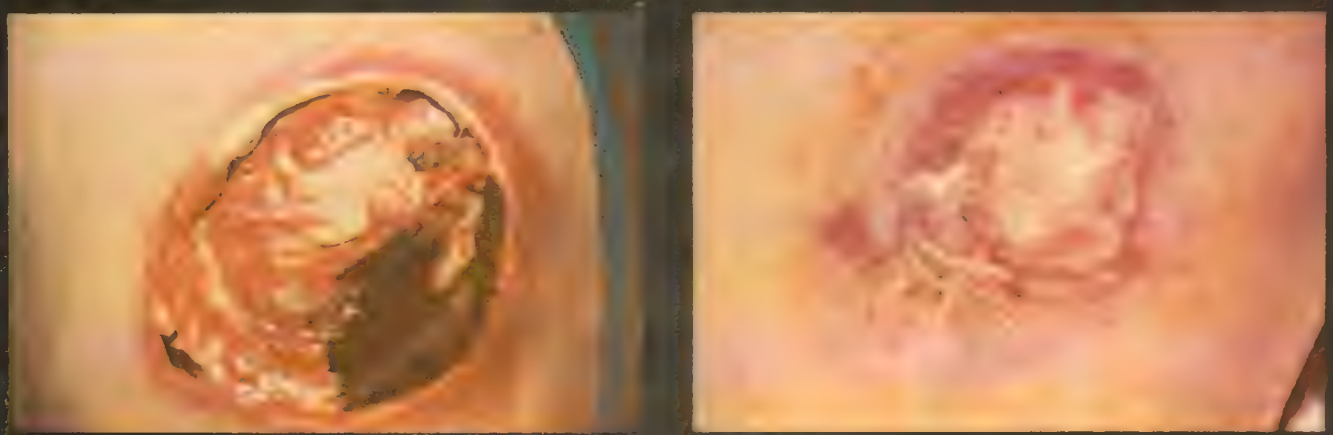
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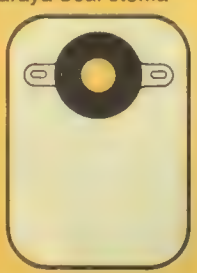
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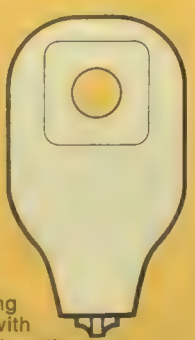
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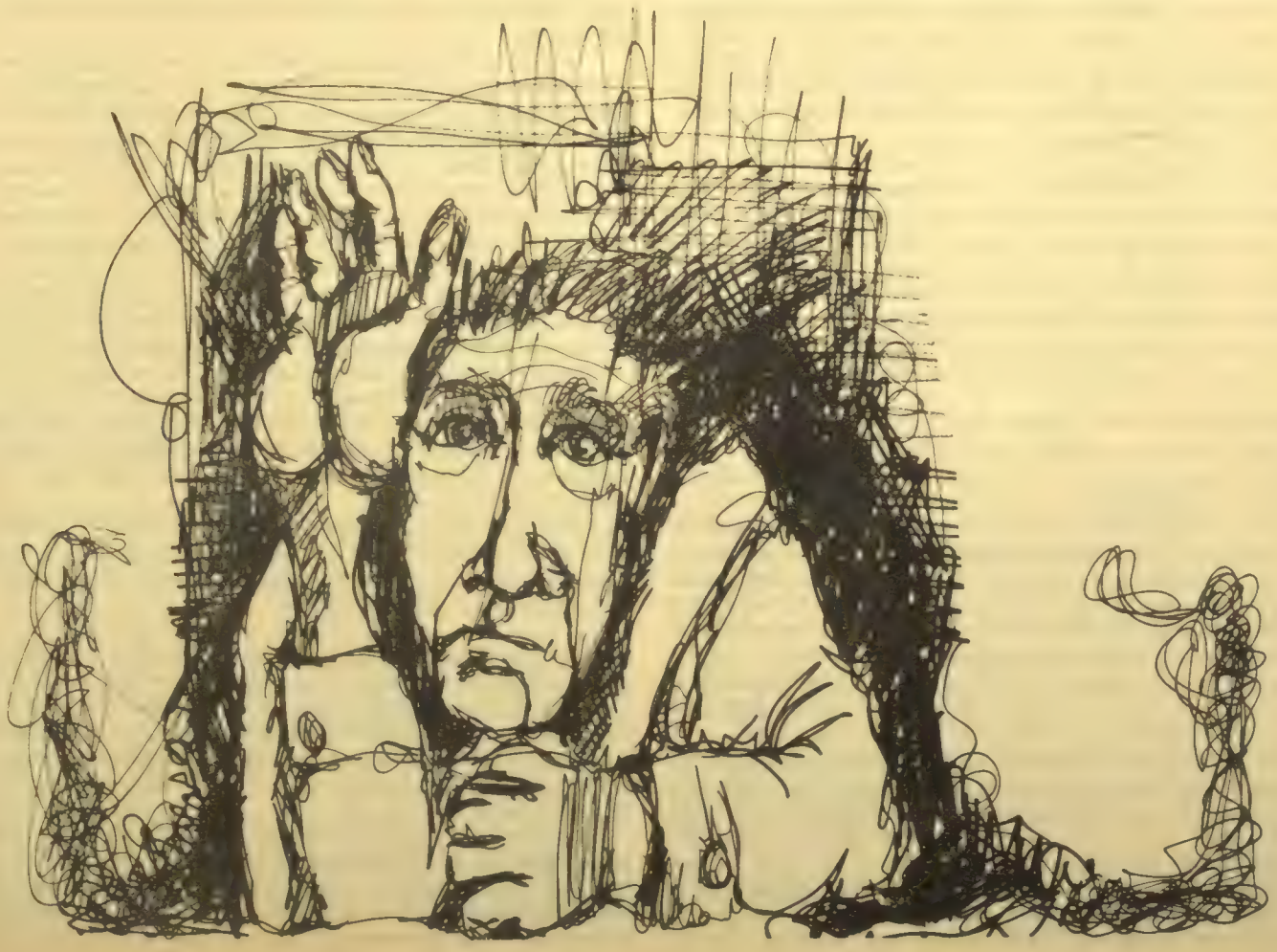
NURSING THE ACUTELY PSYCHOTIC PATIENT

Janet B. Berezowsky

The acutely psychotic patient poses a special threat within the general hospital setting because staff is frequently unaccustomed to dealing with such behavior. Management of these patients can be effectively achieved by using appropriate measures to reduce the anxiety of the patient, staff, other patients and visitors. Here, Janet Berezowsky outlines the nursing interventions necessary to deal with the acutely psychotic patient and the steps that can be taken to reduce the anxiety of those around him.

Acutely psychotic patients are being seen more and more often in the general hospital setting. Yet frequently the staff who must cope with them have had little or no experience in dealing with this type of patient. The bizarre and often threatening behavior of the psychotic can be very frightening both to staff and to other patients; its occurrence in the hospital presents major management problems.

The central problem in coping with the acutely psychotic patient is anxiety — anxiety of the patient, anxiety of the staff and anxiety of other patients and visitors. If the anxiety of the patient is dealt with by using appropriate medications and nursing interventions, psychotic behavior can be controlled within 24 hours of admission, and symptoms can be greatly reduced within a week. The anxiety of staff, visitors and other patients, while it may seem less immediate than that of the acutely psychotic patient, is still an important factor. Reducing the anxiety of those surrounding the patient minimizes the threat not only to those involved but to the psychotic patient himself.





The Patient

The patient experiencing a psychotic episode, brought to hospital frequently under pressure of family or police, is certainly expressing anxiety. He is frequently hallucinating and preoccupied with unreasonable and bizarre fears. He may be physically aggressive or acutely suicidal. The psychotic patient *has lost control,* control of his ability to relate effectively to the demands of his reality situation, control even of the decision to seek medical help. He will often attempt to assume control in the only way he can — to leave the hospital.

Because the situation presents itself in such an immediate and extreme manner, nursing interventions must be guided by certain priorities:

• *Explanation of intent:* The first and most essential therapeutic maneuver is to take control for the patient. It is important that the patient be provided with an explanation of his experience; that is be informed that he is having difficulty controlling his behavior and his thoughts, and that for the present this responsibility will be assumed by the treatment team. A brief explanation of the treatment plan should be given, his cooperation should be requested and the staff should proceed to take control. Staff must take care to do this in a caring rather than a punitive fashion since the patient is particularly sensitive to punitive approaches at this time and is easily provoked to "fight or flight."

Although the plan to take control is usually conveyed to the patient by the treatment team in the emergency room, when the patient is transferred to an in-patient unit it is desirable for at least one member of the assessment staff to accompany the patient and to relate the plan to unit staff in the patient's presence. The intent of hospital staff will be reinforced if the assessment team remains in the unit initially and assists unit staff to assume control by administering medications, removing street clothing and, if necessary, re-explaining to the patient the plan originally made in emergency.

• *Administration of medication:* The most commonly used medications are antipsychotics, but antidepressants and barbiturates may be added to this regime. The initial medication should be given I.M. or I.V. in a dosage large enough to quickly sedate the patient. The actual dosage will depend on the patient's age, body weight, the intensity of psychotic symptoms, and the previous use of such medications, but nurses should be familiar with appropriate dosages. Liquid medication may be more acceptable to the patient, but pills should not be considered since there is little assurance that the patient will actually swallow them.

If a choice of liquid or I.M. medication is to be offered, both should be prepared so that, should the liquid be refused, staff can immediately proceed to give the medication intramuscularly. Medication should be presented to the patient in the privacy of his room, (or cubicle if the patient is still in emergency), and staff should block the patient's most likely routes of escape by standing between him and possible exits. The patient should be informed of the plan and requested to cooperate.

It is likely, however, that the patient will attempt to resist the staff at this early stage of treatment. In this event, staff should be prepared to use force in administering medication. All those involved should remove glasses, watches and rings which could be broken or damaged and might inflict injury to the patient in a struggle. The staff member who has the best relationship with the patient should be in charge, to speak to the patient, give direction to the staff and administer the medication. The presence of at least three to six staff members is necessary for safety, and very often this show of force is sufficient to reduce the likelihood of a struggle. If only one or two staff members attempt to medicate the patient, he will likely struggle and staff and patient may be injured. More than six staff members intensify the patient's anxiety and may precipitate a struggle.

To administer medication, staff members should move in close to the patient. Often when patients realize that argument or discussion will not alter the intent of the staff, they will accept liquid medication without struggle. At least one member of the staff should remain with the patient until the medication takes effect.

Such behavior of the staff clearly conveys that they are in control and, when this procedure is used, patients rarely resist after the first three or four doses of medication. In any event the above approach should be used until the patient willingly accepts medication.

Regular administration of medication every 4 hours for the first 48-72 hours is usually essential. Since the antipsychotic effect of the phenothiazines takes about five days to develop and the mood-elevating effect of most antidepressants takes even longer, the sedative effect of these medications will be the initial means of control. The patient should be drowsy but care must be taken to be sure his level of consciousness has not been severely depressed and that his vital signs following assisted mild exercise are satisfactory. If the patient's blood pressure is very low (less than 80/50) it is preferable to withhold medication for an hour or so and do passive exercises with him, dangling his legs over the side of the bed and assisting him to walk about in his room. In determining the safety of administering the next dose of medication, the nurse should be certain that the patient can be roused, that he responds to pain and that his hand grips are moderately firm. An increase in psychotic symptoms, particularly visual hallucinations, probably indicates toxicity. Very close observation of the patient is essential at this stage of treatment.

Once the patient requires waking in order to administer each dose of medication through the night, it is usually safe to give the same total amount of medication in a q.i.d. regime. Within 5 to 7 days the dosage can usually be reduced.

• *Removal of street clothing:* To tell a patient that we want him to remain in hospital and allow him to keep his street clothing gives him a very ambiguous message. Once the initial dose of medication has begun to take effect, the patient should be requested and assisted to change into hospital pyjamas. Asking him to disrobe before being sedated frequently increases his anxiety because he may fear a sexual assault.

All street clothing should be taken from the patient and locked, and visitors should be supervised to be certain they are not bringing clothing to the unit for him. If the patient is kept in hospital pyjamas he will be easily identified if he attempts to leave the hospital and he can be returned without necessarily involving public or police assistance.

• *Daily nursing care:* Once the patient's immediate needs have been met the emphasis of nursing care shifts to his daily physical and emotional needs while he is in hospital.

In treating the acutely psychotic patient it is essential that adequate fluid intake be maintained (1500-2000 ml/24 hr). This can usually be accomplished by offering oral fluids regularly, as often as q1h. The patient should not be left to make the decision whether or not to drink, but should be informed that he will be assisted to drink. The nurse should position him, put the fluid to his mouth and direct him to swallow. An elevated temperature or symptoms of toxicity are common signs of inadequate hydration. The consistent and caring attitude of the staff in meeting this basic need will facilitate the development of a trusting relationship.

Acutely psychotic patients tend to prefer water, juices, and simple sweet foods which require a minimum of chewing or preparation before eating. Because of their reduced activity, together with the side effects of medication and an erratic eating pattern prior to admission, psychotic patients frequently develop constipation. They should be questioned several times a day, assisted to the toilet regularly, and provided with laxatives p.r.n. until they are able to resume activity and diet patterns which will prevent such complications.

The acutely psychotic patient should be given a low bed or mattress on the floor to reduce the possibility of injury due to falls. Regular exercise periods, where the patient is assisted in passive exercises by one or two staff members, should be arranged to prevent respiratory and circulatory complications (hypostatic pneumonia and hypovolemic shock). The patient's vital signs (temperature, pulse, respiration and blood pressure) should be monitored before each dose of medication. Because the anticholinergic effect of medications increases the risk of damage to mucous membranes, regular mouth care is essential. Regular bathing, turning and positioning, and massaging of pressure areas is also very important to prevent breakdown of the skin. Smoking should be controlled and supervised. The patient should be informed prior to each nursing intervention, so that he does not perceive it as an assault. All of these attentions, which form the basis of good nursing care, help to convey to the patient that the staff is concerned about him and is looking after his needs. This knowledge that the staff is in control serves to reduce the patient's anxiety and increases his feelings of safety and security.

The patient should be provided with a quiet, restful environment free of distracting noises, activity and objects. A locked room is a poor solution unless staff are with the patient continuously; the feeling of being abandoned will only increase the patient's anxiety. In an unlocked room, frequent regular visits to provide reality orientation and basic physical care soon allay the patient's anxiety and enable him to cooperate with the treatment plan. Reality orientation should include calling him by name and telling him your name, that you are a nurse, that he is in hospital, explaining your immediate nursing intervention, telling him the date and time of day and any other significant information such as doctor visits or family visits. Expression of psychotic ideas should be responded to with kindness. It is important to acknowledge that you understand the ideas or feelings which he expresses and to describe reality clearly and simply. Discussion and arguments serve only to strengthen the patient's psychotic ideas. A limited number of consistent staff should work with the patient in this phase of treatment in order to keep reality relatively simple for him, and to develop a therapeutic relationship which is essential for a successful outcome in the convalescent phase.

Anxiety Surrounding the Patient

Particularly when the acutely psychotic patient is first brought to hospital, his behavior is likely to cause anxiety in those around him. In order to deal effectively with the patient and create a therapeutic environment, it is essential that this anxiety be minimized.

Anxiety of the nursing staff can be greatly reduced by careful application of the approaches described above and by effective teamwork. The nurses who care for acutely psychotic patients frequently require the assistance of their colleagues to provide adequate, safe nursing care and to ensure even temporary relief from this demanding regime. New staff should never be designated to care for such acutely disturbed patients until they have had an opportunity to observe and assist in the regime. Detailed teaching and supervision should be provided until staff are comfortable and able to make safe judgments and provide skilled care to these patients.

Physician-nurse teamwork centers around two points: the physician's reinforcement of the treatment plan to the patient, and the provision of adequate medication orders to prevent further uncontrollable psychotic behavior. The physician who is defining the treatment plan should present it to the patient initially, and reinforce it frequently. This may be done verbally or by actually assisting with specific interventions such as the administration of medication or electrotherapy.

The availability of sufficient immediate assistance to deal with possible crises is essential. Crisis situations should occur infrequently once this regime has been established. When they do they are usually due to failure to obtain adequate medication orders, failure to use the medication ordered, or failure to provide very close supervision until continual control is established.

Anxiety of other patients, relatives and visitors can be reduced by giving them simple, factual information about the patient and the means by which the staff are maintaining control, and by ensuring that they are not left alone with the acutely psychotic patient. Fear of unpredictable, uncontrolled assaultive behavior is intense for the uninformed single observer. If a struggle is anticipated, it is advisable for nursing staff to remove other patients and visitors from the area and for at least one staff member to stay with the patients who have been removed. Simple, factual explanations should be provided in a calm, concerned manner.

Family members should be encouraged to maintain contact with the patient during the acute phase. Their visits should be short, supervised and facilitated by nursing staff. Explanations of the treatment plan as it proceeds should be provided regularly for family members and for other patients on the unit. This helps greatly in maintaining a therapeutic milieu for other patients in the setting.

Conclusion

The suggestions above for dealing with acutely psychotic patients center around the problem of anxiety. They are intended to help staff in a general hospital who are frequently unaccustomed to dealing with acutely psychotic behavior but who are being confronted with this type of patient more and more often in their daily routines. In order to deal appropriately with what often threatens to become a crisis situation, nurses can develop the skills to deal appropriately with these patients and to reduce their anxiety and the anxiety of those around them.

Janet B. Berezowsky *(R.N., B.S.N., B.A., University of Saskatchewan) was head nurse of the psychiatric unit at the Royal Alexandra Hospital, Edmonton, Alberta at the time that she wrote "Nursing the Acutely Psychotic Patient." She had previously worked as a staff nurse, head nurse and clinical instructor in psychiatry. Since then she has returned to school and is working towards her M. Sc. in Family Studies at the University of Alberta.*

Frankly Speaking

So You Want to Make a Comeback

L. Patricia R. McMeekan

There are many clichés in nursing by which the profession sells itself short. How many times have *you* heard the following:

- "At least *nurses* will always be needed."
- "Once a nurse, always a nurse."
- " A nurse is also a teacher."

Fallacy number four is one that has only recently appeared on the scene. It goes like this: "To teach nursing is a nice way to get back into nursing." The implications of this statement are cause for alarm and concern.

In the institution where I work there are many part-time clinical teachers. In advertising for these positions the necessity for recent active nursing experience is always stipulated. In spite of this, almost one third of the telephone enquiries I have received about these jobs in the past two years have begun along lines like this:

Enquirer: *Hello, I am interested in your advertisement for part-time (or even full-time) teachers. I have been out of nursing for 5 (10 or 15) years, and I feel that this would be a nice way to get back into it.*
Recipient: *What have you been doing during the last five years?*
Enquirer: *Oh, bringing up my family, which is a good experience with which to help students, don't you think?*
Recipient: *We require the teachers, especially the clinical ones, to have recent experience. What type of nursing was your specialty?*
Enquirer: *I worked in a doctor's office (or Obstetrics, or Public Health, or something somewhat specialized). I graduated 12 years ago from the 'good old three year program.' Surely you are not saying that all this experience is of no value.*

This type of conversation is a composite of many, but the theme has been very similar ... that to have nursed at all is sufficient preparation for teaching it.

I suggest that nurses who are contemplating re-entry into the profession by the "back door" of teaching, would do well to ask themselves the following questions:

1 Assuming that the majority of nursing students are between 17 and 20 years of age, how do I regard young people in this age range ... as children, or as 'becoming adults'?

2 How do I feel about students as a group ... are they basically trustworthy or untrustworthy? At what point on the growth and development continuum do I expect to find them?

3 What sort of person am I ... do I need direction and structure, or am I self-directed and flexible?

4 Am I willing (and able) to spend a lot of home and/or family time on the preparation, study, marking of papers and the myriad of other tasks that are part of teaching?

5 What is my concept of teaching ... standing on a dais in front of a class handing out information or as a nurse watching a student carry out a procedure? (In a cynical vein, many perceive the latter as the teacher standing with arms folded).

6 How do I perceive the learner ... as passive and receiving, or active, participative and challenging?

7 Should a learner evaluate himself, or should *I* be telling him?

8 Could a learner evaluate me ... could I accept it if it were negative?

9 Should the learner make mistakes, or does that mean that my teaching was poor or unsuccessful?

10 How well do I remember the principles of teaching and learning ... or did I ever learn them?



In *Reality Shock,* author Marlene Kramer identifies a group of people found in nursing schools. These are the *Lateral Arabasquers* who have achieved very well as nursing students but are frustrated as registered nurses, feeling that they are unable to carry out the level of care which they have been taught. So, they become nursing teachers!!!

Occasionally a registered nurse with considerable expertise in recent nursing care feels that she would like to share this with nursing students. Undoubtedly, a person with such a background could provide excellent learning experiences for students.

However, the teaching of nursing requires more than the ability to demonstrate care. The teacher, in any field, should be able to cope with self-direction in the use of her time. Nurses have a particular problem in transferring from the traditionally highly structured service setting to an environment of considerable flexibility. In a nursing school, even small items such as coffee breaks (except while in the clinical area) are highly individual and are planned by the teacher herself. Other than scheduled classes and interviews, the timing of the teacher-work is up to the teacher. If the would-be teacher is a dependent person, to an extent, and prefers a fair degree of predictability in the day's work, then he/she should re-examine his/her goals.

If these goals include teaching the students all the things which you were not able to do as a registered nurse, then the students will soon get the message that nursing education is an exercise in futility. They will learn little about the combination of idealism and reality that is essential for adequate performance as a professional registered nurse.

If your goals include conveying to the students how unfortunate they are not to have had a three-year program in a hospital school ... think again! Forty years ago nurses in Canada endorsed two facts:

- Education should not be paid for with service.
- Education should be conducted mainly in educational institutions.

Today, finally, this dream has become reality and yet some of us continue to behave as though the concept were a new one. The two-year program was justified by experiment starting in 1948, and has been functioning increasingly effectively since 1960, producing 'beginning' graduates, not 'finished' ones. Their potential, in many instances untapped, is many times greater than that of the so-called 'better' three-year programs. It is a well-known fact that persistent enforcement of behavioral expectations eventually produces that behavior. The graduates of today are being "boxed into" an inferior position by the unproved expectation that they will be poor practitioners. Registered nurses in the service areas are not alone in conveying these sentiments: as teachers, we convey them too, indirectly perhaps but the students hear such statements as: "If only I had more time to teach you properly" of "Of course, spending so much time on arts courses lessens your time for nursing," and so on.

If you really would like to teach nursing, give serious thought to your philosophy of nursing education. Do you want a nurse who knows just that ... or do you want a nurse who has the kind of broad knowledge base that enables her to understand other people's problems as well as to solve her own personal and professional problems.

I am not condemning the 'old' programs: I feel that, to be proud of one's training and to be defensive in the face of change are two different things. I am very proud of the training that I received (and it *was* training!) but that does not mean that I must blind myself to the possibility that anything better could be developed.

The author of this month's Frankly Speaking, Patricia McMeekan, B.Sc., M.Ed., is assistant director of nursing at Sheridan College School of Nursing in Mississauga, Ontario. She bases these observations on her experience in nursing education in that province and also on the assumption that "clinical teaching, especially in the diploma nursing program, occurs mainly in the hospital setting."

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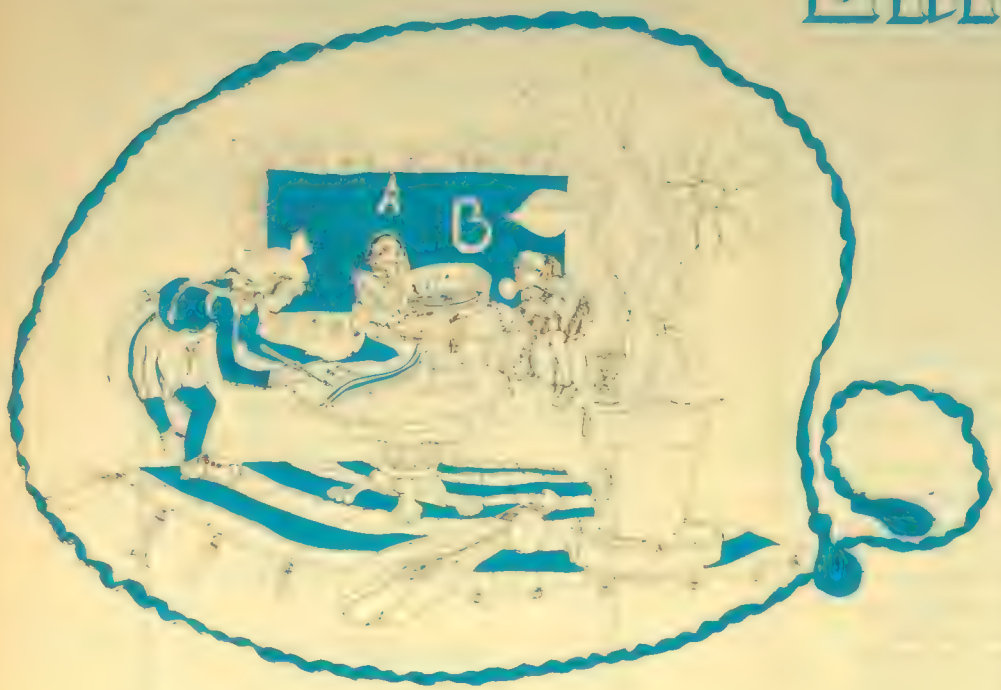
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SINGING SIGNING SMILING

Total communication for non-verbal hearing children



MaryDean Samanski

Little people who could not ask for a cookie, a drink, or their shoes ... who could not say "hello," "I'm cold," or "please help me" ... who could not ask for a favorite record, toy or song. Worst of all, perhaps, who could not make the adults around them realize how much they really did know ...

These were the non-verbal, hearing, developmentally handicapped children at Durham Centre in Whitby, Ontario, just a little more than a year ago. As staff members caring for them, we had no guidelines, no literature, no adviser, only a book on sign language and the strong desire to help these little people find a way to communicate with their counsellors, teachers, parents and peers.

It was the Speech Pathologist at the Centre, Karen Portigal, who conceived the idea of teaching sign language through the medium of songs and music. I was a Registered Nurse also employed at the Centre as Recreation and Crafts Instructor, and Karen's enthusiastic collaborator. When she left, I continued to carry out the program with the assistance of the faithful volunteers who had been involved in the music program from the beginning. On most days, the child-staff ratio was four to one.

Our original aims were to teach signs, stimulate language and, where possible, develop speech. We wanted the children to learn to identify and ask for necessities, to express some feelings and to be happy with their accomplishments. The program had only just begun when we realized that we were also motivating the children to want to communicate and to use signs and/or speech. The first step was to give a sign and verbal clue that represented a concrete object, which the children would imitate. The children progressed from this to the spontaneous use of signs. Next came the ability to vocalize with meaningful sounds and words.

It did not occur to us when we began that we would open up a new world to these children — a world in which they could learn to think, make decisions, feel worthwhile and even entertain themselves. We see children with poor self-concepts begin to develop an improved image through "I" and "me" songs, dancing, signing in the mirror and a lot of laughing and hugging. When babies start to talk they babble, gurgle, coo and are smilingly encouraged by Mom and Dad. In our daily classes we laugh a lot and use every opportunity to encourage a child to participate at his own level. For example, a sneeze is a good opportunity to say "atchoo" and use two vowel sounds. If a child cannot say "atchoo," he can at least laugh at everyone who does.

Each 45-minute session begins with a lively, sociable "welcome" song that encourages us to be comfortable with one another. We greet our friends with signs and words like, "**Hello,** how are **you?**" "**I'm** just fine, how are **you?**" "**Sit** down, have a **seat, good** to **see** you here with **me.**" etc. In order to avoid confusion, we sign only key words. I then ask the children what **record** they want to **hear** and someone will sign **drum.** A "noise" song opens with a booming kettle drum, inviting us to beat the drum and say "boom, boom, boom." It tells us to make the "greatest **noises** in the whole world that **come** from **you** and **me**" by **clapping, stomping, snapping, coughing,** kissing, laughing and whistling. Shouting "wahoo" singing "O" and a surprise, for example a request to be quiet, are all included. This record teaches us to sign, vocalize, sing, find **me**, find **you** and have fun, all at the same time.

The choice of props and songs is limited only by the imagination of the leader. Almost any favorite song, for

example, can be used to teach the signs for common objects such as food, clothing and animals. I am particularly fond of Paul Nordoff's songs because they are especially written for developmentally handicapped children. These songs, along with the props we use, encourage spontaneity and creative thinking in the children. One of the props we use is a baby puppet. Our **baby cries** and **I cry: baby sleeps, I sleep, baby says** "mama" and each child attempts to say "mama." Some succeed, some do not. A popular addition to our visual aid equipment is a battery-operated dog that walks and says 'bow-wow'. The children indicate to me by the signs for "walk" or "talk" what they want the dog to do. In this way we elicit spontaneous signs and/or words. Most of the children respond appropriately (i.e., in sign language) when asked their name. It is very important to use their names in a pleasant manner, for example in songs. Those who are unable to do so, will imitate their own name signs after being shown.

At "sit and talk" time the children are asked **what** they would like to **talk** about. They choose by sign or sound from a box that contains pictures, puppets, etc. One day there was no response from anyone, not even Jamie the most responsive, dependable child "leader."

This is what happened:
Instructor: "Shall we **talk** about a **bus**?"
Jamie: folds his hands and shakes his head.
Instructor: "Shall we **talk** about a **bird**?"
Jamie: negative again.

I was shocked! Jamie did not want to do anything. I looked at Helen — she shook her head. I looked at Rick — he shook his head. It took me a few seconds to grasp the significance of their reaction. Jamie was thinking! He was making a decision and standing by it!

On another occasion, I was busy with Nancy, who was beginning to sign and, therefore required a considerable amount of my time. Jamie tapped me on the shoulder. All Jamie's communication is by gesture. He can only make a "ba" or an "aa" sound. He signed **butterfly on** the **flower.** The message was very clear: he was not getting enough attention and, feeling that he should be included, he decided to make me aware of his presence. This was evidence that Jamie was thinking, communicating, and managing his environment. It is important to recognize that these were not reflexive, impulsive acts on his part, but were the result of logical thought processes. Of course the reward for this conversation and all that it implied, were hugs and laughter from us, and butterfly on the flower for Jamie.

Group dancing and partner dancing give the children occasion to socialize and cooperate as well as move around during the session. Dancing also aids in the development of coordination and body awareness and is a good way to teach such things as **boy, girl,** and other signs. A child may request by signing that we **dance** or play a **record** — an excellent way to socialize and get approval from the rest of the group.

Language acquisition and speech development (where possible) are



long-range goals. We do not offer the children any material reinforcements. Certainly, if we did provide reinforcements, we could elicit predictable responses at scheduled times but the children would still only produce isolated sounds and gestures. It would take years of training and bushels of Smarties to produce enough words or signs to communicate effectively. The rewards these children receive are the feelings of confidence and self-esteem they earn through their accomplishments. The social approval of the volunteers, staff and other children is reward enough.

All the eleven children of one group and seven of another have shown progress. They have advanced from one to two or three simultaneous signs and/or words. Some are speaking or gesturing spontaneously to communicate; others have remained at the level of imitation. It is important to keep trying with all the children — we do not know for sure why signing works or when it will work. My contention is that the accepting, happy atmosphere and the ability of music to stimulate emotional response in these children, in conjuction with an eclectic approach that encourages input from many sources, are responsible for the success of music-signing.

One of my little friends is a boy who was non-verbal and was only able to make incoherent sounds a year ago. One day he was listening to "Look," a song from a Sesame Street record that we had played a few times. He jumped from his chair, ran to the window, opened the curtain and said clearly and distinctly, "look car." At the same time he made the sign for "look" and went around to each child in the circle saying,"look car, look me, look tree," etc. An "l" is a difficult consonant to pronounce and his articulation was perfect!

No diagnostic labelling, no assessments or tests, and no data to analyze. All these have been intentionally avoided in our program. Instead, we concentrate on the children and their individuality. The success of the music-signing program is in the happy face of the child who is understood, who knows that he can understand, and in the enthusiasm of the little fellow who combines signs, song and speech to say, **"Look car, look tree, look me."**

MaryDean Samanski *(above) who wrote "Singing, Signing, Smiling," is a Registered Nurse with extensive experience in the field of psychiatry and mental retardation. For the past six years, she has worked as a Recreation and Crafts Counsellor, employed exclusively in music programming. Since September 1976, she has been on leave of absence from Durham Centre for the Developmentally Handicapped at Whitby, Ontario. She describes her studies in "Early Childhood Education" as "an attempt to supplement my years of practical experience with theory" and says that she is finding her sabbatical "very enlightening."*

She is a member of the Canadian Association for Music Therapy, Ontario Music Therapy Association, Orff Society of Canada, College of Nurses of Ontario and Canadian Society for the Prevention of Cruelty to Children.

Accountability: a professiona

Muriel A. Poulin

Public confidence in the health care system particularly in the medical services — and in the mind of the public the two are synonymous — is at a low ebb. News media reports of spiralling costs and consumer demands attest to obvious consumer disenchantment. For years we have believed the propaganda that Western, and particularly North American, health care is the world's best. There is evidence, however, that for the human and financial resources we expend, and considering the fact that we represent some of the most technically advanced countries in the world, the system is ailing.[1]



Nursing as a Primary Health Profession

As part of that system, what is nursing's state of health? What is nursing's role and its responsibility in assuring that the health care delivery system is revitalized and made whole? If we are to be accountable as professionals we must give some thought to what it is that makes nursing unique among the health professions and to what it has to offer the consumer. Three key elements of nursing require clarification and reassessment:

1. The Nurse as the Client's Alter Ego

The various criteria or characteristics of a profession are familiar to all of us. There is some agreement that these include a body of knowledge, a code of practice, professional organization, and client service. In my opinion, the critical element is the service focus. It is within this frame of reference, a client orientation, that we must clarify our role in the system. Our first responsibility is to the client — the patient — or to an aggregate of clients or patients that is, the society in which we find ourselves.

In the typical bureaucratic organizations in which we function, we have all too often allowed policies, routines and regulations to dominate and determine the role of patients. We have ignored individual needs and their implications for organizational change and have worked to maintain the organizational status quo rather than to meet needs of patients. It is time that each of us recognized that as a primary health care profession we are accountable — not to the organization, not to the medical staff, not to the system — but to the clients we serve. This is our first imperative!

mperative

2. Code of Ethics

Nursing has persuaded society that it should have certain powers and privileges, among them, control over nursing education , admission into the profession, and licensure. As evidence of its ethical posture, the profession has a code of ethics which is a commitment to its clients. The International Council of Nurses has a code that has been approved by member organizations of the ICN including Canada. In the United States, the American Nurses Association has developed a code specific to the American scene. These are all forms of contracts with the patient and with society and I suggest it is high time for us to reassess our responsibilities within the context of these stated beliefs and to determine clearly our accountability.

3. Standards of Practice

The standards of practice enunciated by a profession are another form of "contract" with clients. As they stand now, the Standards of Nursing Care enunciated by the Canadian Nurses Association imply competencies representative of primary care professionals.[2] The question facing us is whether we will indeed function according to the standards and hence as primary care providers; whether we will indeed function to the extent of the potential inherent in the nursing profession. If we are going to try to alter the system, we must first answer this crucial question concerning our role in it.

There is no doubt that the system will be altered and that the change will involve a power struggle of many groups and elements. Whether or not nursing will have significant input into that change will depend on its competence and confidence as primary care providers.

Throughout its history, nursing has maintained altruistic goals but altruism without authority is seldom influential. All too often our aims have been mighty but our "might" has been aimless. If we believe in our professional goals, it follows that we support the position of our professional organization. We accept its code of practice and we identify with the profession. Professional associations of nurses, cutting across the many spheres of the occupation, at the local as well as national and international levels, offer one of the most promising means of achieving nursing's aims. It is only through collective action that the authority of the profession will be exercised.

The role of professionals and their professional organization in determining standards and controlling practice is something we need to look at. We are living in a period in which the quality of the health care system is being questioned and at the same time better qualified practitioners are being introduced into the system. Graduates of baccalaureate programs can be expected to exert more and more influence as they demand a greater voice in determining practice. Those of us who are already in the system will be forced to decide whether we identify with nursing as part of the system or with particular institutions. One need not negate the other but priorities must be decided. Values must be weighed and a balance established between client needs and organizational responses to these needs.

Barriers to Professional Development

Today, the quality of care in many countries is not equal to the human and technical potential that exists in these countries, including, probably, Canada. Organizational, political and legal constraints have functioned to limit roles and to restrain group and individual development. If you think this is too broad a statement, consider:

- the failure of nurse-midwives to gain acceptance.
- the role of the nurse today compared to 25 or 30 years ago. Formerly the nurse provided most of the care except for the physician's diagnosis and medical orders. In terms of the knowledge of that day, both roles were "extended." There was a complementary lack of knowledge, whereas today both have a firmer knowledge base. Why did the knowledge: practice ratio in nursing fail to keep pace? We are not, on the whole, providing the quality and type of care possible in relation to the knowledge base available to us.
- the specialist role today compared to the head nurse role two or three decades ago. The head nurse was truly a primary care worker and clinician — in the real sense of the word — again in relation to the day's knowledge. Why was the role not maintained through the years?
- failure to include third-party payments to nurses as national health insurance plans developed. Did this contribute to full utilization of nurse potential?

Obviously, nursing has not yet found its appropriate role in the structure of today's health care system. I believe that there are four major forces in society that have conspired to prevent our role enactment as professionals: medical dominance, female subservience, political naiveté, and low visibility. These constraints know no barriers and influence all of us, regardless of position.

Medical Dominance

There is no doubt that the dominance of the medical profession in the health care system has seriously limited the exercise of nursing's potential and thus the quality of health care in general. The tendency of medicine, particularly organized medicine, to concentrate on the interest of its own profession has not always been in the best interest of the larger society. Its efforts to maintain the status quo rather than encourage social developments are well documented.[3]

Much closer to our own professional practice is medicine's newly awakened interest in the broad health picture. With the development of family nurse practitioners who can deal with the broad spectrum of family health needs, we must expect more involvement from medicine in health — as opposed to illness — care.

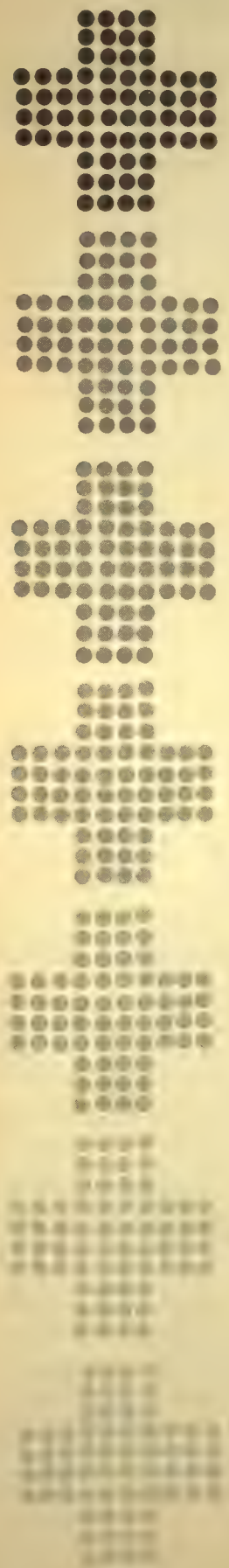
In my opinion, control has evolved largely as a result of medical chauvinism. However, I believe that the practice of increasingly competent nurses will result in lessening of the medical mystique and greater awareness on the part of everyone that M.D.'s are not gods, but people of a scientific endeavor, with all the limitations, as well as skills, of mortal beings. I also believe that medical dominance cannot be considered outside of the male-female role question.

Women's Role

I agree wholeheartedly with Rothberg, who states that "our oppression as women health workers today is inextricably linked to our oppression as women..."[4] We have traditionally faced overwhelming conditioning and indescribable brainwashing in learning women's "proper" role. As we all know, women's role is not intellectual. It is emotional and it is family-centered. It is dependent and nonaggressive. It is not, of course, a leadership role!

However, things are changing and there is an opportunity in today's society, particularly with the women's movement, to assert ourselves. It is now more acceptable for women to take definitive, initiating roles. Women are increasingly career oriented, regardless of their level of education, and more and more of them are working outside the home. It is obvious that the focus of activity for many of us is not in the home. Our lifestyles require satisfaction in contributing to and being "part of the action." In view of the state of the world, which is an outcome of long male dominance, I suggest it is long past time for women to play a greater leadership role in all aspects of our society.

Certainly, as health care providers, we must become more assertive. Failure to question what we consider shortcomings in care is a disservice to our patients. If the quality of care is to be improved, nurses must function to their full potential. This means



throwing off the subservient role of women and maintaining active involvement in decision-making as health care providers.

Political Naiveté

We live in the midst of political structure and yet we are politically naive. In the health care system and in the individual health care agencies, there are definite power bases, power centers and power structures. There is continual competition for control and obvious shifting distributions of power. Relationship patterns display a variety of combinations of coalitions and alliances and a wide range of negotiation styles are evident in the many confrontations.

Unfortunately, nurses have usually been on the fringe. We've avoided confrontations rather than acquiring skills in negotiations. We've developed patterns of avoidance rather than confidence in risk-taking. We've avoided true leadership roles rather than face conflict resolution.

In the arena of power and authority, nurses — women, mostly — have been "programmed for failure." Authority to make decisions may be frightening, or at least anxiety-provoking, for it means breaking out of the security of dependency roles and being held accountable for the results of our decisions.

It also means the need for discriminatory judgment in understanding the nature of power and the values of shared power. We are living in a time when the dominance of any one group is to be deplored. Effective use of control will focus on public rather than on private interests and, for us, it will focus on providing nursing care services for all. If we are truly serious about our goals of meeting nursing needs of patients, we must be responsive to the political struggles going on in many of our agencies, and we must be equally serious about our involvement in policy decision-making.

Such involvement will depend on the power and prestige afforded us in these agencies but we must avoid the trap of acquisition of power solely as a struggle for prestige and control. We must be cautious that use of power is for positive purposes. We must maintain our goals and focus the power we acquire on goal achievement: i.e. health needs of the people.

My concern is with the existing imbalance in the power structure of the health care system to the patient's disadvantage. And it is with nursing and its appropriate role in that structure and system.

Low Visibility

In order to attain power in any system, a group must have recognized status and prestige based on a variety of factors such as wealth, expertise, political popularity, position in formal organizations and numbers. Nursing is not likely to achieve its strength from an economic base in the near future. It has the potential, however, of achieving strength based on expertise in a critically-needed social service, and certainly it has the potential for power based on numbers.

It is time for us in nursing to change our public image, to improve our visibility, to inform the public of the extremely essential and positive contribution made by nurses and the nursing profession.

For too long we have shied away from self-aggrandizement as a profession. I suggest that we, as individuals, must inform the public of nursing's contributions; but I also suggest that it is time that our collective efforts be directed toward a massive public relations campaign, one that will inform the citizens of our society of the primary and prominent role played by nursing in the total health care scheme. The public must be told how nursing is, and could be, contributing to its health needs.

Recognizing our accountability

Paraphrasing Freud's question: "What do nurses want, my God, what do they want?" Essentially, I believe, we want greater freedom; freedom to function to our fullest potential, to contribute as primary health care professionals and to determine our own destinies as essential health practitioners. We want equity in our social and economic status. We want an end to the medical dominance of the health care system with its major thrust of medical care rather than consideration of total health needs of our society.

The next five to ten years will be critical ones for the nursing profession and for the health care system. The effects of economic problems and cutbacks in health expenditures are already being felt. As nurses who accept our professional accountability, what can we do? The first step, it seems to me, is to get involved, both individually and collectively, in all aspects of change. I would recommend that:

. Initially, we must commit ourselves to reassessing our beliefs relative to nursing practice. Regardless of the setting or the position in which we function, basic beliefs must be clarified.

. We must reaffirm the primary role of nursing and the inherent authority residing in that role. We must speak up as knowledgeable practitioners in our daily practice, whether as staff nurses, administrators or educators.

. We must assume individual as well as collective responsibility to interpret nursing's role to members of the public as well as to other health professionals.

. We must be confident in our roles as professional practitioners. We must all throw off the shackles of the traditional, subservient women's role and function as full human beings. Whether male or female, recognize your worth as professional nurses.

. We must inform ourselves of the power centers in our agencies. We must all "tune in" and utilize the political structure in achieving nursing care goals. We must choose leaders who are educated, intelligent, articulate, and who have the inner fortitude to stand up for what they know is right for the patient and for nursing.

. We must overcome the anti-intellectualism so pervasive in our ranks and recognize that only in functioning on a par with highly educated, well prepared, scientifically oriented health professionals will we influence developments in the health care system.

. Finally, we must strengthen our professional organizations, local, national and international. Collective action can accomplish what individual effort cannot.

I believe we must define our beliefs and develop the inner fortitude and commitment necessary to take an aggressive and initiating role in promoting change in the health care system. We must become increasingly self-conscious about our practice, our educational preparation and our research. We must recognize our accountability and function as the patient's advocate.

We have a vital stake in the health care system, not only as providers but as consumers as well. The system of the future will depend in large measure on our ability to clarify our roles. It will depend on our astuteness in planning strategies for overcoming barriers to our role enactment as primary health care professionals. In short, it will depend on our ability to demonstrate our accountability as professionals and as a profession. In the days ahead, this is the imperative that nursing will have to face.

Muriel A. Poulin, *R.N. Ed. D., FANN, author of "Accountability: a professional imperative," is professor and coordinator of the Graduate Program in Nursing Administration, Boston University School of Nursing, Boston, Mass. She received her doctorate from Columbia University in New York. Dr. Poulin believes that "we have traditionally faced overwhelming conditioning and almost indescribable brainwashing in learning women's 'proper' role" and points out that women have only recently begun to overcome some of their inhibitions. "In view of the state of our health care system," according to Dr. Poulin, "it is time for nursing to exert sound and definite leadership."*

This article is based on an address she gave to mark the opening ceremonies of Memorial University School of Nursing's 10th anniversary celebrations in St. John's, Newfoundland, last Fall.

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reproduction and the

A MUTED EXPLOSION...

"The popular press and lay science writers exhibit an understandable fascination with the more exotic possibilities of genetic engineering: test tube babies, chimeras, and clones. But while they write and societies fantasize about spectacular events which may take place in upcoming decades, they often ignore the quiet and more muted revolution in human genetics which is occurring right now — a muted explosion ... of knowledge and techniques which may be having more impact on parenthood, on the family, and on the rearing of life itself than cloning ever will..."[1]



Photo by Health and Welfare Canada

test tube baby

Lucille Pakalnis, Josie Makoroto

Any discussion of man's investigation into the reproductive process is guaranteed to evoke strong reactions, ranging from praise and enthusiasm to condemnation. There is scarcely an area of human endeavor more heavily shrouded in myth than that of reproduction. But right now, investigation into reproductive technologies is going on; knowledge in this area of the medical sciences is proliferating rapidly. The development of technologies attending such knowledge ensures that its influence is being felt more and more.

As nurses, we are closely involved in the technologies; first as professionals in the health field, especially in the care of patients in research units; secondly, as members of a society whose fabric and structure may be affected by their use.

The work going on in the reproductive technologies carries with it a range of questions, a number of serious ethical and moral implications. But for the present, let us look at where the reproductive technologies are now, and at where they may be going. Our bibliography suggests a fraction of the works available on the implications and possibilities inherent in the development of such technologies, but we will look at the technologies themselves.

Hands Off...?

Public response to what is happening in the area of reproductive technologies seems to be related to the perceived motivation for research. Acceptance is greater when the result of research is more than merely informative, when it is perceived as being helpful to people. For this reason, Edwards and Steptoe in England have had little difficulty in finding volunteers for their research, (which includes in vitro fertilization) because their motives are seen as humanitarian; they wish to offer help to childless couples through their studies.[2]

But an uninformed public cannot make a sound judgment; the 'unknown' threatens. And in the area of human reproduction, there are so many unknowns involved. For example, we are just beginning to be aware of the tremendous effect the prenatal environment — the same environment such research attempts to recreate and work within — has on the ultimate outcome of the fetus.[3,4]

Another area of concern hinges on the status of the fetus in the eyes of the researcher. Is the fetus in fact, a human being, with the rights of a human being? Is it on a par with lab animals, such as rats and mice? Is it a discrete tissue, useful for organ function studies? The question needs an answer, as such an answer will form the basis for the course of the research itself.

Public reactions to investigation into the reproductive technologies tend to be strong, whether in favor or in opposition. This can be expected because such investigation goes to the heart of what man is, or seems to be, and presumes to alter that somehow. But valid opinions must be based on fact and not on myth.

Fig. 1 **Reproductive Technologies: Goals, Problems and Questions**

Goals

1) to understand the actual process that occurs during fertilization.
2) to assist fertilization in childless couples.
3) to enable monitoring of pregnancies, in order to detect genetic defects, (e.g. Tay Sachs disease and Mongolism) and cure/eliminate/abort these.
4) to supplement/replace natural reproduction with lab methods (IVF-IVC) to allow greater control over the number and quality of fetuses.
5) to alter the genetic pattern of the fetus, either to correct an existing error or to enhance a particular "favorable" trait.

Problems and Questions

1) currently, artificially produced embryos cannot be maintained to viability, and must be sacrificed.
2) "About 10% of couples are infertile due to genetic defect." [5] This defect could thus be perpetuated through genetic assistance.
3) some will escape detection due to lab error or sheer number of pregnancies to be screened. How will society treat these individuals?
4) would remove reproduction from being a family event; depersonalizing; could normal psychic development of the fetus occur?
5) DNA structure is extremely complex — there is danger of accidentally inducing further damage with repair attempts; could interfere with natural mutations allowing adaptation to our evolving environment, and jeopardize our race's survival.

At the heart of the research, is a sincere appeal to go beyond myth, beyond the sacrosanct "hands-off" approach to examining such a fundamental aspect of humanity; to attempt to discern what is essence and what is explanation; to be able to act out of choice rather than because of limitation; and thus to arrive at a clearer, more accurate understanding of man's place in the universe.

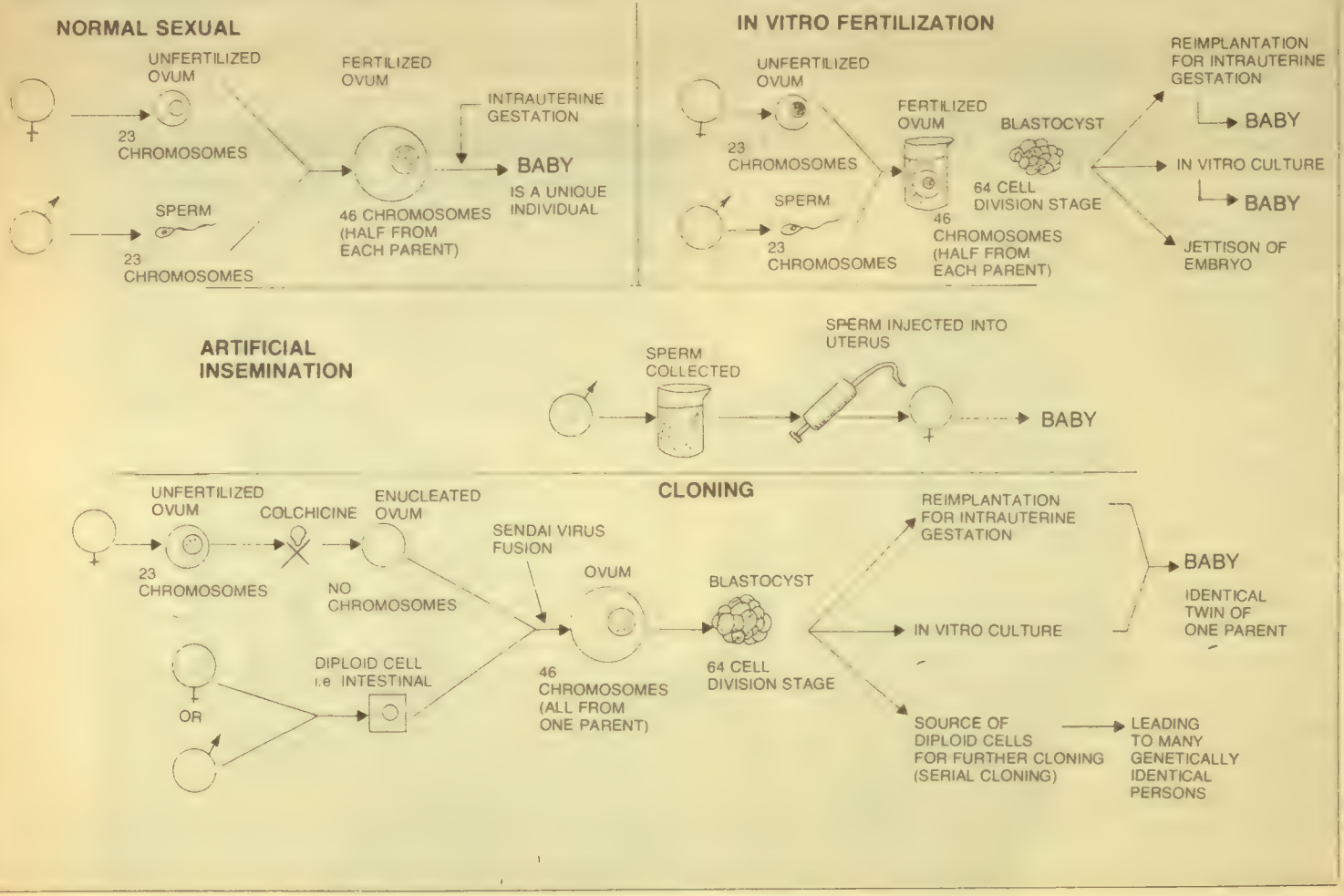
Goals

The goals of research into human reproduction are attended by problems and very fundamental questions. Some of these are outlined in Figure 1.

What is going on...

The various techniques described seek to

Fig. 2



understand and enhance the processes involved in the fertilization of a human ovum. They are depicted in Fig. 2

Artificial Insemination

Artificial insemination has long been used as a practical, efficient means of breeding animals. This procedure is now popular in assisting fertilization in childless couples. An estimated 10,000 children are born annually in the U.S. through the use of this method.[6]

Sperm from the husband or a suitably matched donor are injected by syringe into the woman's cervix at the time of ovulation. The sperm may be fresh, or have been previously collected and frozen for storage. Impregnation frequently occurs after two or three such treatments. Several problems are created by the possibility of artificial insemination:

- donors must be found with similar physical and intellectual characteristics to the husband
- donors must be found who have families free of known genetic defect
- religious, psychological and legal complications must be dealt with; they tend to cause further distress if marital discord develops
- feelings of inadequacy in the husband must be dealt with; the common misconception confusing sterility and impotence must be cleared up

Controlled Ovulation and Harvesting of Ova

Under controlled hormonal stimulation, a woman's ovaries can be induced to mature one or more ova on a schedule known to the researcher. These ova are then removed by laparoscopy and aspiration. From the woman's point of view this procedure entails little risk; but the chance of damaging the ova removed by a method relatively violent to them is great.

In Vitro Fertilization

The harvested ova may then be fertilized in vitro (i.e. in glass, a test tube) with the addition of human sperm. Visualization of this process by means of a microscope has revealed what a complex procedure fertilization actually is. Rather than occurring at a given moment, it spans a time period of up to 12 hours, with several discrete steps between contact of the sperm and ovum, penetration, and fusion of the nuclei. Any disrupting influence (i.e. bacterial/viral contamination, altered chemical environment, etc.) could lead to failure or to defective development of the resulting embryo.



In Vitro Culture

In order to determine that IVF has in fact, occurred, and that cell division is progressing normally, the embryo is maintained in a chemical bath and observed closely. As yet, this may only be continued up to the blastocyst stage, or 64 cell divisions, the stage at which the fertilized ovum is normally travelling down the fallopian tube to the uterus. Beyond this stage cellular specialization and organ growth begin, producing the as-yet-unsolved problems of oxygenation, nutrition, and waste disposal, normally provided for by the now implanted embryo's placenta. Once the IVF embryo has reached this stage of development, the researcher is faced with three options: to attempt reimplantation of the embryo into the uterus for intrauterine gestation, to attempt to continue IVC with an artificial uterus, or to discard the embryo.

A major difficulty lies in the fact that the only apparent way to discover a supportive artificial environment is to expose the embryo to a series of hostile ones, a process of elimination. An entirely new living organism is created by IVF, and then because of our limited knowledge, exposed to what must be considered to be lethal conditions.

Embryo Re-implantation

It is at this stage that such scientists as Edwards and Steptoe, are trying to devise methods for transferring the embryo back into the uterus for IUG (intrauterine gestation).

One method involves an abdominal incision into the uterus, but this has its drawbacks. It requires major surgery and traumatizes the uterus, which may lead to spontaneous abortion.

A more promising method lies in the insertion of a fine tube through the cervix and injection of the embryo into the uterus. To date, most sources state that this has not yet been accomplished (most embryos fail to implant, and one implanted in the fallopian tube). One researcher, Dr. Shettles of Columbia University, claims to have succeeded using the syringe procedure on a woman scheduled to have a hysterectomy. At operation, two days after the reimplantation "...an examination showed that it had implanted properly..."[7]

Cloning

For the sake of completeness, cloning should be mentioned, but the technical problems involved with such a delicate maneuver are such that it seems a much more remote possibility.

In cloning, the haploid nucleus (containing half the normal complement of



Photo by Health and Welfare Canada

human chromosomes, or 23) is removed from an ovum and replaced with a diploid nucleus (containing all 46 chromosomes), perhaps from an intestinal cell. The now "fertilized" ovum begins to divide and ultimately produces an individual identical to the donor of the diploid nucleus. To date, this has only been done with reptiles such as frogs and salamanders, although work is progressing on perfecting the technique in mammals.

Awareness

Scientific investigation into the reproductive technologies is going on, and its going on now. The 'muted explosion' of knowledge and techniques is already making itself felt in the areas of artificial insemination and prenatal genetic testing and counselling. Man as we know him, and all that we call life, is under close scrutiny.

Microscopic exploration is giving rise to as many questions as the answers it uncovers. With advances in this area, new dilemmas and responsibilities are created. The establishment of centers for bioethics is an expression of the need for answers to the puzzles created by scientific investigation and proliferating knowledge.

Perhaps our first responsibility is to be aware as much as possible of what is going on in the sphere of reproductive technology. From here, we can begin to deal more knowledgably with the questions that will confront us.

About the Authors

This article evolved from a course in bio-medical ethics attended by the authors at the University of Sudbury. **Lucille Pakalnis** *(R.N., Montreal General Hospital School of Nursing, Montreal, Quebec) and* **Josie Makotoko** *(R.N., South Africa; P.H. Aberdeen) both have extensive obstetrical experience, having worked in England, the West Indies, Africa and Canada. Currently, both are living in Sudbury, Ontario. They feel that the subject of reproductive technology is one "of tremendous importance to all nurses, both personally and professionally. At present Canada has no formal policy governing such research, and the public at large is similarly unaware and uninvolved in the matter. This is a very unfortunate state of affairs, as ignorance of any aspect of nursing having so potentially profound an effect on our lives is a serious handicap."*

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Statistics show that a large percentage of patients discharged from conventional psychiatric facilities are readmitted, not because of recurrence of pathology, but because of their inability to cope with what to them is an alien and hostile world. As one alternative to traditional psychiatric care, nurses working at the Lakeshore Psychiatric Hospital established a self-care unit on an experimental basis. Its staff members were confident that the supportive environment they were able to provide and its emphasis on greater patient responsibility could ease the transition for patients from hospital to community and result in fewer readmissions.

The self-care Unit: a bridge to the community

Patricia Barrington

Patient Study No. 1

Twenty-four-year old John Gordon* was admitted to Lakeshore Psychiatric Hospital for the second time in March, 1975. One of five children of divorced parents, he had a long history of mental retardation even though he had completed Grade 8. Psychological testing done at the hospital showed a dull normal I.Q. with social and emotional immaturity. Following the previous admission, John had spent a year and a half in a sheltered home before being removed by his father, and sent back to his mother in March 1975. John's mother resented this, and the resultant problems precipitated his current readmission.

When John was first transferred to the Self-Care Unit in July, he annoyed fellow patients and staff with his childish tricks and immature remarks. When he did not receive the attention he wanted, he would go off by himself and sulk. In contrast to this behavior, however, he took responsibility for the tasks assigned to him on the unit and obtained a job with Hospital Services. He surprised the staff there with his efficiency, reliability and intelligence. With frequent reassurances from staff and co-patients, John became better able to interact on an adult level and was soon talking about discharge plans. His medication was gradually reduced and then discontinued entirely.

With help from staff he found a basement apartment in the community and upon discharge, moved in with a fellow ex-patient from the Self-Care Unit. Both young men managed very well cooking their meals, and working regularly. Also, John's relationship with his mother improved dramatically and she asked him to accompany her on a vacation. John has remained stable and self-sufficient in the community and continues to perform at a high level at his job in Hospital Services.



* Names have been changed and details altered to prevent identification of individuals but the essential facts are taken directly from the histories of three of the patients who took part in the program.

In July, 1975, we established a Self-Care Unit on an experimental basis at Lakeshore Psychiatric Hospital in Toronto. It was designed to provide a commune-type atmosphere for ten to twelve chronic male patients between the ages of eighteen and forty-five. Operated by one R.N. and one R.N.A., 24 patients have stayed on the unit over a 7-month period. Four of these patients were transferred back to their original units because they refused to accept the responsibility which went with the additional freedom offered in the Self-Care Unit. Twenty patients, John Gordon among them, have been discharged to the community and have not required readmission.

A self-care unit setting provides a psychiatric patient with a transitional experience to bridge the gap between hospital and community living. In this warm, caring and supportive environment, our goal is to help the patient to relearn and practice living skills and to develop a feeling of responsibility towards himself and his fellow patients, thereby increasing the probability of his successful return to the community. By nature of its minimal equipment and staffing, its reduced number of readmissions and its subsequent reduction of hospital bed occupancy, it also offers a maximum of economy in a time of financial constraints.

A typical program which initiates and promotes a sense of responsibility in the patient towards himself and others may include:

- a written committment or contract by th patient regarding his goals, objectives and probable length of stay in the Self-Care Unit
- responsibility for household chores on commune basis
- responsibility for personal medication
- preparation and serving of breakfast an lunch in the Unit
- participation in group discussion to encourage communication and the development of insight
- assistance in voluntary work in various hospital departments for specific periods every day
- discussion of job possibilities and opportunities or various upgrading program available in the community
- participation in the investigation of suitable accommodation and social recreational facilities in the community.

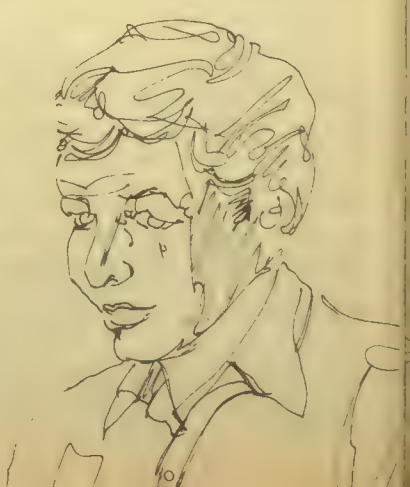
Mature and experienced staff are necessary to provide the consistent suppor and guidance that each patient in the self-car unit needs. As the noted psychiatrist, Dr. William Glasser states, the staff must achiev "the proper involvement, a completely hones human relationship in which the patient, for perhaps the first time in his life, realizes th someone cares enough about him, not only t accept him, but to help him fulfill his needs i the real world." The staff of a self-care unit must have the personality and maturity to direct such a program.

To maintain the continuity of personal contact that is the very heart of the program staff members should be on fixed hours rath than rotating shifts, so that patients know whe and where they can find the particular individual they wish to consult.

Prior to their transfer to the Self-Care Un many of these patients had poor prognoses but the changes that have occurred are considered remarkable by the staff of the hospital. The studies that follow serve as examples of the progress psychiatric patien can make in a self-care unit environment.

Patient Study No. 2

Larry Black was 24 years of age with a Grade XIII education. His mother and father were both



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professional people and he had two younger sisters. His first admission was as an involuntary patient after being transferred from a general hospital with a diagnosis of schizophrenia. In November 1974, Larry had been difficult to handle and had left hospital several times.

During his first admission to Lakeshore he was withdrawn, isolated and seclusive. He was treated with Chlorpromazine until his discharge to a private sanatorium. One week after his discharge from the sanatorium, he was readmitted to a general hospital. When the staff found him difficult to manage, he was again readmitted as an involuntary patient to our hospital.

Upon admission, Larry showed thought-blocking, delusions and experienced auditory hallucinations. He also had a history of self-destructive acts, and, one hour after admission made an attempt to jump out of a third-floor window, but was restrained by staff. With the administration of electro-convulsive therapy and phenothiazines, the psychosis subsided quickly but he still remained seclusive.

In early April, plans were made to place Larry on day care. However the weekend before his discharge, he slashed both his wrists at home. In May, he began working in Industrial Therapy, but again, slashed his wrists after an upset caused by a fellow patient.

Over the summer months, Larry showed some improvement. His general affect was good and he was verbalizing more. In September, he started a general preparatory course at a Community College but he seemed anxious about it. His medication at the time included Chlorpromazine, Moditen, Stelazine and Kemadrin.

When Larry arrived in the Self-Care Unit, he was very shy and withdrawn. At first, he was reluctant to speak out at the morning group sessions, but as he got to know his fellow patients and staff he was able to express his opinions quite well. Larry took responsibility for the duties assigned to him. He attended his Community College course daily and spent weekends with his parents. After awhile, he told us of his real fears about pursuing higher education. He felt that his family expected this of him but he preferred to work at something less intellectually demanding. In solving this conflict, Larry made plans to get a job and completed all the necessary arrangements himself. At the end of December, he was discharged to a halfway house, suggested to him by the staff, and there, experienced greater independence and became popular with the other men in the house.

Although he had needed a great deal of positive reinforcement and support to make these moves, he made them, and has not been readmitted. His medication has been reduced to Moditen injections every two weeks and Cogentin. His relationship with his family has improved and he visits them, but not as often as before. Now, he depends more on friends in the house and people in the community.



Patient Study No.3

Tom Brown, 28-years-old, had completed Grade 9 and was employed as a laborer. His family history was poor. His mother was a manic-depressive, his one brother had been a psychiatric patient at Lakeshore and his father seemed totally indifferent to his family's problems. Tom also had one sister.

Over a period of four years, Tom had been admitted four times with increasingly severe diagnoses of amphetamine psychosis, schizophrenia, personality disorders and drug abuse. Most recently, he was admitted after taking an overdose of Chloral Hydrate tablets, his second suicide attempt in a short period of time. Although quiet, withdrawn and lethargic, he settled in fairly well on the ward and by late June, he no longer felt suicidal. He was closely observed by staff for a month, however, and was granted limited privileges.

On admission to the Self-Care Unit in November, a psychological assessment showed that Tom had marked schizoid features, suffered from depression in schizoid personality and showed signs of borderline schizophrenia. He required intensive individual and group relationships that would provide him with the support he needed to further his independent functioning and rehabilitation. His medication included Nozinan and Cogentin.

Like many patients coming to the Self-Care Unit, Tom lacked self-confidence. But in a short time, he seemed comfortable and accepting of the emotional support on the Unit and he was able to speak up at the daily group sessions. He took responsibility for his own chores and lent emotional and psychological support to his co-patients on the Unit. He worked daily in Industrial Therapy, participated in social activities in the hospital and community and eventually became enrolled in an upgrading course in a Community College. His relationship with his parents improved and he achieved insight into his relationship with his brother, who had been upsetting him frequently in the past with his problems.

Tom was discharged in February 1976, to a room in the community and until this time has remained independent of the hospital except to return for a minimum dosage of Moditen.

In his book, "Reality Therapy," Dr. William Glasser states that everyone has two basic psychological needs — "the need to love and to be loved, and the need to feel that we are worthwhile to ourselves and others." Psychiatric patients for one reason or another are unable to fulfill these needs and have become irresponsible because they have never learned how to meet them.

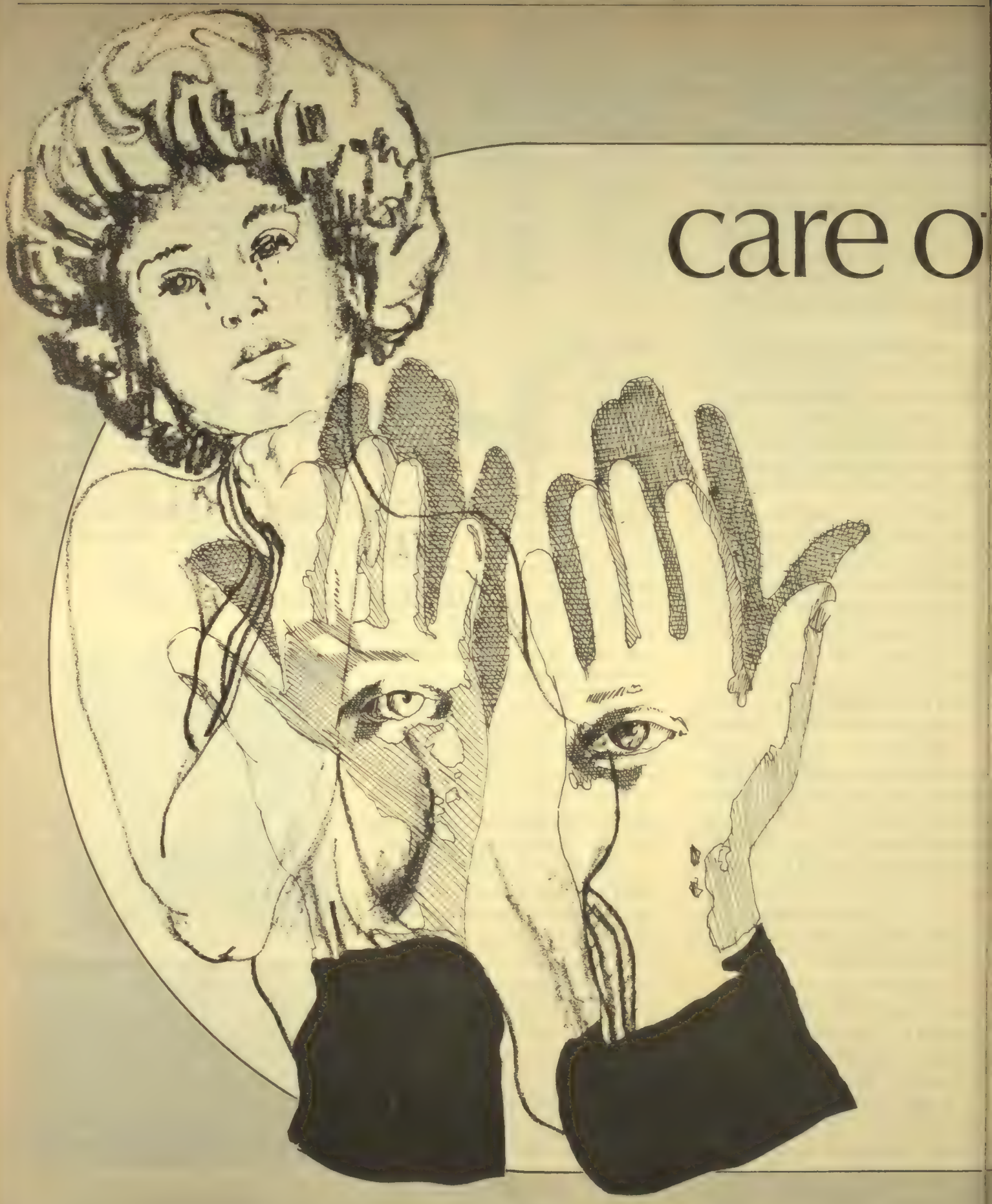
In a similar vein, another psychiatrist, Dr. Victor Frankl in "Man's Search for Meaning" says, "the therapist should increase the patient's responsibility. He/she must not protect the patient from conflict but show him how he may overcome it himself; demonstrating that he has untapped reserves of strength just as an architect may strengthen a decrepit arch by increasing the load upon it, forcing the parts more firmly together."

It is the aim of the Self-Care Unit to help the participants in the program develop this feeling of responsibility which will enable them to give and receive love and to build the self-esteem and independence necessary to live outside the institutionalized or hospital setting.



Patricia Barrington, *(R.N., St. Mary's School of Nursing, Montreal) is presently nursing at Lakeshore Psychiatric Hospital in Toronto. In July 1975, she developed and organized the 12-bed Self-Care Unit which was an offshoot of a rehabilitation program using a token economy system. In February 1976, the unit was expanded to a 45-bed facility.*

Barrington is presently a member of the Health Planning Committee of the Social Planning Council of Etobicoke, Ontario and is taking courses towards her degree.


care o

The nurse working in emergency is in an optimal position to develop a therapeutic relationship with the woman who has been raped. The hospital experience can be made a helpful one if staff are open, understanding, and knowledgeable in their treatment and support of the rape victim.

the rape victim in emergency

Sandra LeFort

If you work in the emergency department of a large center, chances are that sooner or later you will be called upon to care for a victim of rape. In 1974, a total of 1,823* rapes were reported to police officials in Canada. This figure, however, barely skims the surface of those who are raped and never press charges. Many more victims arrive at a hospital for help than these statistics would have us believe. Experts estimate that only one rape in ten is ever reported.

Some hospitals in Canada have refused outright to treat victims of rape while others show varying degrees of cooperation depending on the hospital staff involved. In the United States, despite nationwide efforts to improve the mental and physical care of rape victims, the situation is not much better. RN magazine (Feb. 1976) reported that many private hospitals have a "shut-door policy" for rape victims and those who are treated have to wait several hours in an emergency room, in a state of shock and with little privacy.

A recent study by workers associated with the Montreal Rape Crisis Centre showed that 78% of hospitals in the Greater Montreal area refused to answer a questionnaire concerning the protocol used in the care of rape victims in their emergency departments. Only 6 out of 13 hospitals contacted were willing to have rape crisis centre workers present inservice education to hospital personnel about the realities and myths of rape, the medical/nursing care required and legal aspects.

Counsellors at rape crisis centres in several cities across Canada, when contacted by CNJ, unanimously agreed on one point: the emotional crisis that occurs in the life of a woman who is raped is often secondary or totally ignored by health professionals in their initial contact with her. One RCC worker in Ottawa described some nurses as "cold and matter-of-fact and seemingly unaware of the emotional support needed by a woman who comes into emergency after being sexually assaulted." This worker emphasized that what is lacking is an informed awareness on the part of nurses about how an assault of this kind affects the victim's behavior.

A counsellor at Rape Relief in Vancouver stated: "Overall, the Vancouver medical people are fairly good but there are the occasional horror stories. Basically, the problem is ignorance and insensitivity on the part of the medical and nursing staff. What they may view as an innocent question i.e. 'Where were you when it happened?' may sound judgmental to the women and be interpreted as 'They think that it was my fault for being there.' We cannot sufficiently emphasize a rape victim's need for understanding and compassion."

Societal attitudes are not on the side of the rape victim. Often, the prevailing attitude is that a woman who is raped had it coming to her; she must have done something to provoke the attack; she is out to get revenge or else cries rape because she is caught in an embarrassing situation. For those working in the health professions, such attitudes can and do prevent the development of helping relationships with women who have been raped.

The woman who has been sexually assaulted needs assistance and support. The nurse in emergency is in an optimal position to use her humanistic skills to decrease the victim's fear and anxiety; to help her to be more in control of her situation by explaining what is happening to her and by listening in an understanding way; and to share valuable information about counselling services and follow-up treatment. In an attempt to increase knowledge and assist in the development of a sensitivity toward the rape victim, the Rape Crisis Centre in Toronto is contacting hospitals and providing inservice education workshops to staff. As well as providing concrete information, sessions also allow for questions and discussion about the attitudes and feelings the staff have about rape. To further aid emergency room personnel, they have published a booklet entitled "Emergency Room Care for Rape Victims." The following guidelines are excerpts from that booklet.

In 1975, the Provincial Council of Women of Manitoba prepared a Brief on Rape which was supported by the Manitoba Registered Nurses Association and the Canadian Nurses Association. Among others, their recommendations included: changing legislation to recognize rape as sexual assault; revising courtroom procedure; expanding counselling and other supportive services; revising medical procedures; expanding public education; providing treatment and counselling services for sex offenders.

In March 1976, the Criminal Code was amended and did incorporate some of these recommendations into the new legislation. The Justice Department has conceded the point that moral judgments are out of place in criminal courtrooms and, correspondingly, limitations have been placed on the defense counsel's right to cross-examine women about their character and past sexual conduct. Such questions may be asked only if the information is essential to a fair trial. Other amendments give the judge great discretionary power. Depending on circumstances, the judge may insist that a victim's identity be kept secret; that the public be excluded from the trial; that the location of the trial be changed — this is particularly beneficial for women in small communities.

Many people, however, feel that the recent amendments to the Canadian rape laws do not go far enough. In response to this criticism, Justice Minister Ron Basford has stated that a general revision of all sexual offenses within the Criminal Code is in process.

Statistics Canada Catalogue number 85-205, annual publication Crime and Traffic Enforcement Statistics, 1974

Guidelines for Care of the Rape Victim

If emergency room personnel are aware of the psychological implications of the rape experience, they have an excellent opportunity to reassure the victim and to help her to regain her equilibrium. If the rape victim does not encounter aware and sympathetic staff, the hospital procedure will probably only further frighten and upset her. Caring for the rape victim's emotional state is more than just an act of kindness. It is potentially the prevention of future psychologic disorders.

1. ***The patient should not be given low priority*** on the grounds that her physical injuries are slight. She is frightened, upset, possibly exhausted and should be examined as soon as possible. This is important for legal as well as medical reasons. Specimens should be obtained for forensic testing as soon after the incident as possible.

2. ***If a wait is unavoidable,*** she should be placed in a private room away from the embarrassing curiosity of other patients. Any unused space can serve this purpose, a conference room for example.

3. ***She should never be left to wait alone.*** The presence of a supportive and sympathetic person is essential. If a rape crisis centre is in your community, a caseworker can be called by the victim or the nurse to provide support at the hospital and to accompany her to the police station or her home afterwards.

4. ***It is crucial that the nurse display a sympathetic, non-critical, and non-judgmental attitude*** towards the victim. Societal attitudes are not on the side of the victim and any attitude which blames her will only serve to abort any therapeutic relationship. It is inappropriate for medical personnel to express any judgments or opinions as to whether rape actually occurred or whether the victim was at fault.

5. ***The offer of small comforts*** such as coffee, kleenex, cigarettes, etc. can be very reassuring and may help her feel more at ease. She should be kept warm at all times.

6. ***Telling her story may be a relief*** or it may be a painful reliving of the incident. In either case, she should have to answer questions only once, preferably to the nurse who remains with her until the medical examination. Any attempt to pressure or force her into giving details of the incident or submitting to the pelvic exam will be experienced as a continuation of the violence and coercion of the rape. There is no need for the woman to relate the entire story to medical personnel.

7. ***The following kinds of information are relevant:***
   - — Medical history: menstrual, contraceptive, VD history, pregnancies, etc.
   - — the time of the alleged assault: whether she bathed or douched afterwards.
   - — whether penetration occurred or if ejaculation occurred elsewhere on her body.
   - — non-genital physical trauma e.g. pain.
   - — whether she scratched or injured the assailant.

8. ***The woman herself has the right to choose the persons she wishes to notify*** about the incident. She may want to contact the police, friends, relatives, or the Rape Crisis Centre. The hospital is under no obligation to automatically call the police.

9. ***All medical examination procedures*** should be explained to the patient in advance. Rape victims need emotional support at this time. The assurance that the examination is happening with her full understanding and consent is very important. Remember that she has just experienced a violation both of her body and her right to consent.

   To protect everyone involved, consent forms should be obtained from the patient for the examination, the collection of specimens and the release of evidence to the authorities.

10. ***If possible a doctor who is sensitive to the implications of the rape*** on her emotional state and her family life should examine the victim. She may find the examination less threatening if it is performed by a female doctor.

11. ***It is never necessary for a police officer to be present*** in the examination room during any part of the physical exam for legal purposes. The examination will include the collection of specimens:
   - — direct smears from vaginal pool and cervix
   - — vaginal washings (10 cc normal saline) for centrifugation and smears and acid phosphatase if indicated
   - — pubic and head hair specimens of the patient
   - — other specimens which may be taken are anal swabs; dried stains on the skin; fingernail scrapings.

If the woman is not sure whether she wishes to report the incident, it is possible to store the specimens under refrigeration for 24-48 hours without contacting the police. Specimens sent to the forensic lab should not be sprayed or placed in any kind of preservative. All samples must be sealed, dated and signed by appropriate staff.

Before and during the medical examination:
   - — explain exactly what is is going to happen. She is probably very frightened and it may be her first internal exam.
   - — make sure a woman is present at all times.
   - — do not expose her any more than is necessary — provide a blanket.
   - — allow her to undergo the internal exam in the position which she finds most comfortable — lying down or semi-sitting.
   - — warm the speculum with *warm* water only.
   - — try to make her feel as comfortable and as calm as possible — it may seem like a second rape.
   - — if she is reluctant to discuss the incident, ask only direct questions relevant to her immediate care and to the collection of evidence.

12. ***In the case of young children,*** a complete internal exam is not necessary. Specimens may be obtained with a sterile pipette. Many large centres have experienced team members who are available to examine and counsel sexually assaulted children and their parents.

13. ***Someone must be available to accompany the woman*** from the hospital to her home. It could be a friend, relative, a police officer or a rape crisis centre caseworker. If she lives alone, suggest that she spend the night with family or friends.

14. ***If the woman appears distraught,*** it may be advisable to encourage her to seek professional counselling. She must understand, however, that this is simply to help her deal with a crisis in her life and does not imply any underlying neurosis.

15. ***Initial responses to sexual attack*** tend to fall into one or two categories —**expressed reactions** such as crying, trembling, nervousness or laughter or— **repressed reactions** such as outward calm, and controlled behavior. She may insist that there is nothing wrong with her. In many cases, the victim with repressed reaction is not believed by staff. In one case, a rape crisis centre worker observed that a nurse would not believe the victim "because she was not crying."

Studies indicate that approximately an equal number of women react in each way. After the initial acute reaction, the victim enters a period of withdrawal or repression when she simply doesn't want to think about the incident at all. It is important for nursing staff to be aware of this stage when recommending follow-up tests for VD and pregnancy. Unless the importance of these tests is impressed strongly on her, she may ignore them as reminders of a painful fact she is trying to forget.

16. ***The woman must understand the need for follow-up treatment.*** Some form of venereal disease or infection is a possible result of rape. She should make appointments at the hospital or with her own doctor for tests for gonorrhea after three weeks and syphilis after twelve weeks.

Many women worry about becoming pregnant although this actually happens in very few cases. If she is at a dangerous point in her cycle, she should be told when and where to get a pregnancy test.

I would like to thank the counsellors at the Rape Crisis Centres in Vancouver, Ottawa, Toronto and Montreal for their cooperation and willingness to help in the preparation of this article. A special "thank you" goes to the Toronto Rape Crisis Centre for their permission to use part of their booklet "Emergency Room Care for Rape Victims."



Suggested Reading

1 Brownmiller, Susan. *Against Our Will. Men, Women and Rape.* New York, Simon and Schuster, 1975.

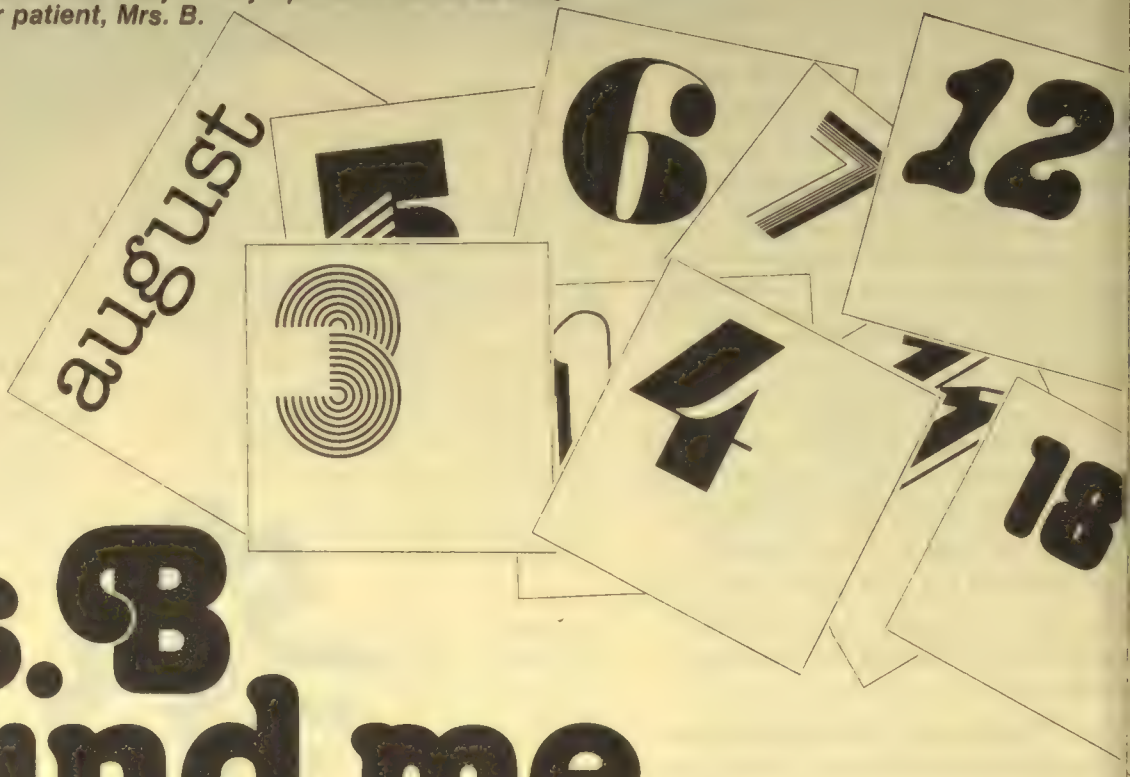
2 Burgess, Ann. Crisis and Counselling Requests of Rape Victims, by...and Lynda Holstrom. *Nursing Research,* 23:3:196-202, May 1974.

3 Burgess, Ann. The Rape Victim in the Emergency Ward by ... and Lynda Holstrom. *Amer. J. Nurs.*, 73:10:1741-5, Oct. 73.

4 Burgess, Ann. *Rape: Victims of Crisis,* by...and Lynda Holstrom, Maryland, R.J. Brandy Co., 1974.

5 Williams, Cindy Cook. Rape: A plea for help in the hospital emergency room by... and R. Arthurs. *Nurs. For.* 12:4:388-401, 1973.

Every nurse has memories buried somewhere of what it was like to be a first year student, meeting totally new experiences every day and having to deal with them — somehow. And there are patients that we can remember as if it were just yesterday. This diary shares the day-to-day 'ups-and-downs' of a first year nursing student, and her patient, Mrs. B.



Mrs. B and me



Heather Sproul

August 3

Am working afternoons all this week...Light was on above 1017, and I walked into the room to find a very thin and tiny patient curled up at the foot of the bed. She wanted to use the bedpan. Noticed that her right arm was extended by an armboard held in place by a Kerlex* bandage, that was wrapped from her hand to her upper arm. She had an IV — and I came to the conclusion that the needle must have been somewhere in the area of her anticubital fossa.

She was also on a cardiac monitor and oxygen by nasal prongs — quite a collection of tubes and wires for a little lady. It seemed to me that she was a pretty sick cookie. Asked if I could have her as my patient the next day.

** Kerlex is a registered trademark of Kendall Company (Canada) Limited*

August 4

Mrs. Burton is officially my patient, and I hope that I've done the right thing in requesting her. I'm pretty sure that I can cope, but time will tell if I've bitten off more than I can chew.

She needs help with meals as she is right handed, and refuses to use her left hand. Her IV is in her right brachial vein... a rather stupid place for it in my opinion, but I guess that sometimes it's a matter of putting it wherever they can find a vein.

August 5

I seem to be coping fairly well with Mrs. Burton. Her intravenous is still in her right arm and she doesn't appear to be any happier about it. Tonight she said that she hates to see her supper tray go, because it means that the doctors are going to come in and fiddle with her IV, and that hurts. When I took her tray away, she was almost in tears.

She seems to be a rather unusual person, "spaced out," very flat in her facial expression. She always seems preoccupied and doesn't have much interest in anything that is going on around her.

She only picks at the food on her tray — tonight all she had for supper was tomato juice and milk. She says that just the sight of food makes her feel ill, and as she eats, a kidney basin is her constant companion.

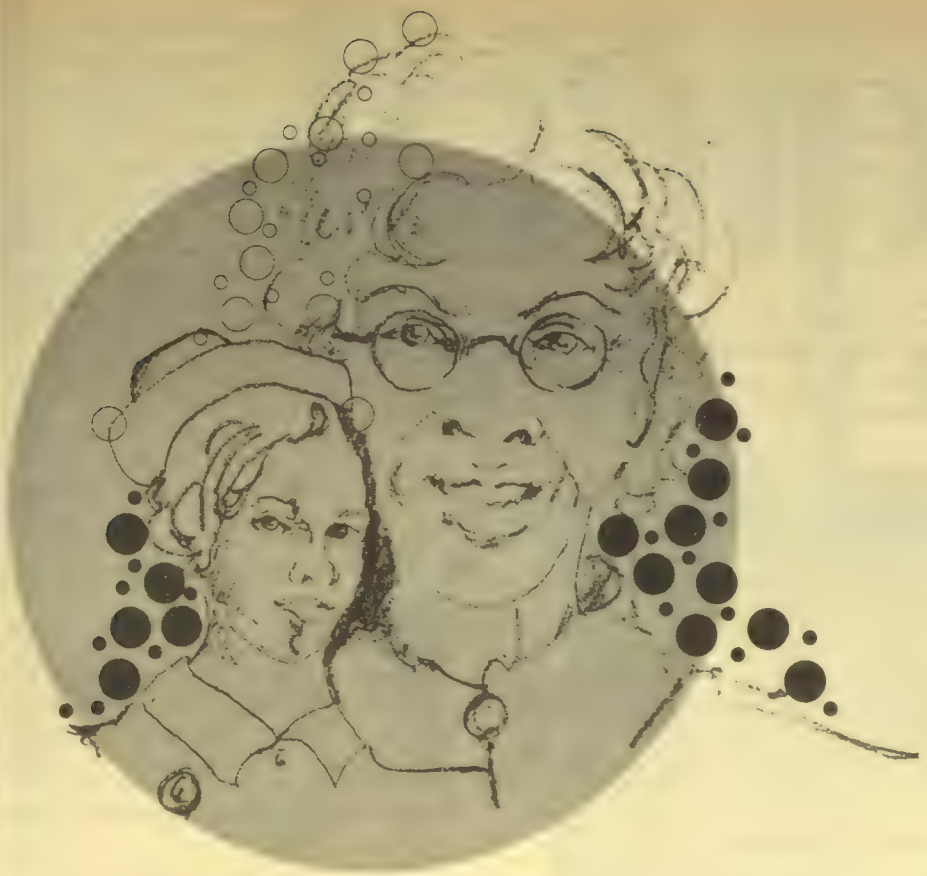
I suppose it isn't any wonder that she seems apathetic, picks at her food, and appears morbidly preoccupied. In my opinion her recent medical history must be very discouraging for her. At 63 years of age, Mrs Burton is married, but has no children. Three months ago, she had a massive myocardial infarction, and was admitted to the Coronary Care Unit at a regional hospital. When her condition was more stable, she was transferred from CCU to a cardiac floor. About a week later, she was transferred to Kingston General Hospital and admitted to CCU there with a diagnosis of pulmonary embolism and congestive heart failure.

By the time I met Mrs. Burton, she had been in the hospital for a long time, and her problems were considerable. She was diagnosed as having peripheral neuritis, congestive heart failure, myocardial infarction, pulmonary embolism, and leukopenia.

August 6

1945 hours

Mrs. Burton complained of sharp mid-sternal chest pains. Her blood pressure was 120/65, pulse 70, and regular. Her face was very pale and drawn. Remembered from my reading that patients suffering one MI will probably have another, more serious, infarction. I figured that she was doing just that, and asked the doctor to take a look at her. After his examination, the doctor asked me what Mrs Burton had eaten for supper. Then he asked me what I thought her problem was. When I told him what I thought, he laughed for what



seemed to me to be a long time, told me Mrs. Burton had indigestion, and asked if he could give her an antacid. He assured me however, that I had been right to call him — that it was always better to be on the cautious side. Did my charting and sat and read Mrs. Burton's lab reports until I went off duty. She has had two bone marrow biopsies done. Will have to do some reading about leukopenia tonight.

August 7

Mrs. Burton was asleep when I went into her room for 1600 hour vital signs. I guessed that the lung scan she had earlier this afternoon had taken the puff out of her.

As Mrs. Burton slept, I began to count her respiratory rate. Her breathing was shallow, and regular. As I counted, the depth of her respirations increased gradually, and then suddenly she stopped breathing for about ten seconds. This really threw me. I thought that she'd had a respiratory arrest, until her breathing began again, shallow and regular. For a few minutes, she followed the same pattern ...Cheyne-Stoking? This time I decided to talk to my instructor before I called a doctor.

Quiet after supper. Mrs. Burton was napping, so I read more of her chart. Still no word on the cause of her leukopenia.

At report this afternoon, our instructor suggested that if we had any spare time this evening, we should look up Valium in the C.P.S., as it is the most widely prescribed drug in the world, and just about all the patients on the floor are taking it. Mrs. Burton has been on Valium since the beginning of her illness. So, when I'd finished with Mrs. Burton's chart, I decided to tackle the C.P.S. and Valium. There it was on page 222 — "the more serious adverse reactions occasionally reported are leukopenia"... hmmm.

Went to my instructor with my findings and she suggested that I talk to one of the doctors about it. The doctor seemed to think that I had taken leave of my senses, and informed me that Valium-induced leukopenia is extremely rare (why can't Mrs. Burton have a rare case of Valium-induced leukopenia?)...Crushed.

1950 hours

Again, Mrs.Burton complained of sharp mid-sternal chest pains. She looked like death warmed-over. Decided to play it cautious again and have a doctor take a look at her. He gave her one nitroglycerine sublingually and Mrs. Burton settled down in about five minutes.

Earlier in the evening, I had placed Mrs. Burton in the textbook position for a person with dyspnea. But when the doctor came in, his first comment to me was that she was likely to smother in all those pillows. So much for my positioning skills.

My last evening. Next week, I'll be on days and Mrs. Burton will need a bed bath. With two IVs, cardiac monitor wires, and oxygen in the way, one of us is bound to get hanged. We'll see.

August 10

At report this morning, found out that Mrs. Burton needs a nose and throat swab to be sent for culture and sensitivity. This should be no problem for me as I've done swabs before in microbiology labs. Plan on doing the swabs before breakfast along with eight o'clock vital signs.

Swabs went without a hitch. So did the bed bath. Mrs. Burton was taken off the cardiac monitor sometime over the weekend, so that meant one less set of cords for me to worry about. Noticed reddened area just below her coccyx. I'd better get out the brown soap, and try better positioning too. (I take the weekend off, and the place falls apart).

Mrs. Burton is still pretty lethargic and has no interest in what's going on around her Thought last week that it might be because of the day's activities, but now I'm more inclined to think that it's due to the long period of time she's been in hospital.

Felt that I was doing a fairly good job with Mrs. Burton until I read her chart this morning. The psychiatric resident was down to evaluate Mrs. Burton yesterday. He found her to be deteriorating mentally, slow, demented, and unkempt. I'll admit that Mrs. Burton's hair is disheveled — it's short, she's between perms, and she's having oxygen by nasal prongs. The psychiatrist is scheduled to see her tomorrow, so I'm going to try to improve her appearance with a snappy new hairstyle before he sees her.

August 11

Things were going fine with Mrs. Burton until breakfast arrived — her IV had gone interstitial, so one of the doctors decided to remove it and restart it after Mrs. Burton had finished breakfast. Mrs. Burton's toast was ice-cold so I toddled off to make her some more. Got back to find that her IV had sprung a leak — blood all over the bed, pouring out from her IV site. Grabbed a couple of 4 x 4's, applied pressure and elevated her arm. Realized that Mrs. Burton is on heparin therapy and that she'll take her own sweet time to clot. During all of this, Mrs. Burton was munching away on her toast, happy as a little clam.

Got the bleeding stopped. Took her tray away and came back in time to see Mrs. Burton's breakfast coming back up. All in all, she vomited 100 mls of undigested food. Guess she was pretty worn out at this point — she practically begged me to let her rest for half an hour before I gave her her bath and did her hair. Fifteen minutes later, guess who walks into Mrs. Burton's room — the psychiatrist and his band of interns and residents (I just can't get ahead!!).

My instructor and I sat in on his consultation. Learned a lot about interviewing from watching the psychiatrist — he has the best technique that I've ever seen — he keeps the whole interview very open-ended, doesn't appear to be rushed and asks very few questions, lets the patient do just about all of the talking. In the huddle outside Mrs. Burton's door afterwards, he stated that she did not appear to be deteriorating mentally at all, but was probably just frustrated with her prolonged stay in hospital. He prescribed home for her just as soon as her physical condition would allow it. What a load off my mind!

August 12
First half of this morning was relatively uneventful. That brown soap and massaging really works — the red spot on Mrs. Burton's coccyx has disappeared. She had no problems with breakfast today.

At about 1100 hours, she said that she wanted to use the commode chair. After about fifteen minutes on the chair, her light went on. Mrs. B. announced to me that nothing was happening and that she wanted an enema or suppository or else she was going to faint. Told her I'd check with one of the nurses and let her know what the verdict was. A nurse suggested that Mrs. Burton sit on the commode for another fifteen minutes. Fifteen minutes later, Mrs. Burton stated that if I didn't give her an enema or suppository, that she *would* faint! (a fact which wouldn't surprise me at all).

The nurse told me that since Mrs. Burton was so determined, it might be best to ask her doctor for a glycerine suppository. So, I got to give my first suppository, and Mrs. Burton got results.

August 13
Decided today to get one of the other students to help me and between the two of us we'd wash and set Mrs. Burton's hair. Found out while we were washing it (in bed) that it hadn't been done for seven weeks. Greta set Mrs Burton's hair while I gave her a bath and the two of us got her sitting up in her chair with th hair dryer. Changed her bed and tidied up th room. Was time for lunch at this point, so we combed Mrs. Burton out and put on her ow nightgown and bathrobe before bringing he tray in. Quite a change — Mrs. Burton glowed Just after her tray was brought in, her husban and sister dropped by to see her. I just couldn believe my eyes — Mrs. B. not only showed a interest in things but ate just about all of he lunch (it stayed down, too).

August 17
Back on afternoons this week. Mrs. Burton i really showing improvement. She asked m what I did to keep out of trouble last weekend

Her chart says that she can be ambulate in her room with assistance, so maybe afte supper, the two of us will go tearing around he room.

Always figured that Mrs. Burton was about four foot nothing in her stocking feet Was quite surprised to find that when she g up out of bed that she's really a lot closer to fiv foot six. She didn't tolerate the rip around h room too well — felt dizzy and short of breat — 'probably partly because she's been in be for so long. Maybe she'll do better tomorro night.

August 18
Mrs. Burton made it around her room twice tonight! She still needs a lot of assistance an encouragement but she didn't get really tire until halfway through the second lap. Tomorrow night I'm going to try to get her walk out in the hall.

August 19
Made it all the way up to the door of the CC with Mrs. Burton tonight. She's beginning t tolerate ambulation quite well and in no time a all, she should be roaring up and down the halls.

August 20
Came on duty this afternoon to find Mrs. Burton's room empty — she was discharge this morning. She's gone, and I'm really goin to miss her. She was an interesting lady, an really learned a lot from her. Thanks alot, Mr B.

Author's note: **Heather A. Sproul** *is current a second year nursing science student at Queen's University, Kingston, Ontario. She wrote this article during the clinical intersession of her first year. She is intereste in specializing in orthopedics or burn therap upon graduation.*

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Books

Essentials of Communicable Disease, 2ed. by Mary Elizabeth McInnes, 401 pages. The C.V. Mosby Company, St. Louis, 1975. Canadian agent: Mosby, Toronto.
Approximate price $10.00
Reviewed by Christina Gow, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, British Columbia.

The author's suggestion that this book could be used as a quick reference is, in the reviewer's mind, a correct one. The text's contents cover a wide range of material, beginning with an introductory section which deals with such topics as historical events, scope of control, immunology, social, psychologic and economic factors, jet-borne communicable diseases, care of patients with communicable diseases and rashes. This section is very general and somewhat repetitious. Reference material dating from the early and mid-sixties is not very current as the book was published in 1975. The author has attempted in this introductory section to present material in an interesting way. One problem involved in such a broad introduction is the sheer bulk of material available.

The author then divides the text into sections dealing with the specific diseases of varied causes:

Section II deals with Bacterial Diseases: Part A — Infectious Diseases and Part B — Enteric Diseases. This classification is confusing, as both Part A and B diseases are highly communicable, eg., Tuberculosis (Part A), Typhoid Fever (Part B). In this section, references cited are again often from the sixties; in one instance(dealing with tuberculosis) the author referred to a 1959 reference on the effectiveness of chemotherapy.

Section III deals with Viral Diseases. A table is presented on page 222 which outlines the classification of viruses, but no reference is cited. This introduction would have been more beneficial had some of the types of viruses been further explained. More detailed information would help the beginning reader, although the book does not claim 'exhaustive coverage.' A further suggestion is that the glossary could have been more detailed.

Sections IV, V, and VI deal with Arthropod-borne diseases, diseases caused by fungi, and Helminth infections. The information in these sections is of use for quick reference.

The treatment sections under each of the diseases are not up to date in all cases eg.: with Scarlet Fever it is stated "bed rest is mandatory for one week."

This text would be useful to student nurses as a reference guide and not as a basic textbook. The writer has attempted to cover many diseases and has presented a source which will be of use as a beginning reference for the nurse.

Diagnostic Procedures. A Reference for Health Practitioners and a Guide for Patient Counseling by Barbara Skydell, R.N., M.A. and Anne S. Crowder, R.N., M.A., Little, Brown and Company, Boston, 1975.
Reviewed by Lou Lewis, R.N., M.Sc.N., Instructor, Nursing Department, Ryerson Polytechnical Institute, Toronto, Ontario.

This book provides a quick and easy reference for health professionals who prepare patients daily for various diagnostic procedures. It emphasizes the need for creative patient teaching regarding diagnostic tests, and for communication with the patient so that he will know what to expect before, during, and after an unfamiliar procedure.

The book is divided into twelve sections. The first section is an overview which deals with an approach to communication, and explains the format of the book. It also discusses such factors as time, patient attire, consent and diet that are common to successful completion of many diagnostic tests.

The next ten sections of the book discuss the diagnostic procedures themselves. The tests outlined include those used in neurology, opthalmology, urology, the biliary and gastrointestinal systems, cardiovascular and respiratory systems, and female reproductive system. Also included are radioisotope scanning, ultrasound and additional procedures. Each procedure described follows a similar format. It includes purpose, time, location, personnel, equipment, technique, preparation, patient sensations, and aftercare. The book covers the most commonly performed procedures and those for which health personnel most often prepare patients.

A positive feature of this book is a listing of sensations the patient may experience as well as points to remember in the aftercare of the patient following each specific procedure.

This book should be used as a basic, handy reference for health professionals. It is not designed as a definitive reference on either a procedure or its diagnostic implications. Rather, it should be most helpful as an immediate source of basic information for patient instruction. It could be a helpful resource for students and practitioners.

Maternal Health Nursing Review. by Josephine Evans Sagebeer. New York, Arco Publishing Company, Inc., 1975.
Approximate price $6.00.
Reviewed by Patty Ellis, School of Nursing, Faculty of Health Sciences, McMaster University, Hamilton, Ontario.

The purpose of the ARCO Nursing Review Series, and more specifically the *Maternal Health Nursing Review,* is to provide nurses and nursing students with a comprehensive review of a specific nursing subject, in this instance maternity nursing. This is done through multiple choice questions plus a few matching questions with answers and brief explanations given at the end of each chapter. Each chapter looks at a different area of maternity care so that there is complete coverage of the subject. The questions and their answers are documented as to their original source. The reader is then able to authenticate all of the material presented if she/he so desires.

The book is certainly comprehensive in its factual coverage of maternity nursing, of both normal and abnormal cases and can be used for examination preparation and continuing education.

It does, however, have several limitations. First, many questions dealing with either statistics or history are irrelevant for Canadians as the information given is American. Another limitation is the quality of the questions themselves. Most of the questions require only memorization of facts. Very few of them require thinking on the part of the reader.

In addition, the technique of writing good multiple choice questions has not always been applied as many errors can be noted in the questions themselves. For example, the use of "all of the above" or "none of the above" as distractors is fairly common throughout the book. Other questions deal with useless information such as asking how many maternal deaths there were in 1963 (page 11, question 27). The final limitation is that the material presented is a review of textbook information which is often outdated due to the time process involved in publication.

Despite the limitations, the book is thorough in its coverage of maternity nursing as this subject is presented in the present textbooks. As long as the reader is aware of the limitations, the book can accomplish its purpose of aiding with the education of nurses and nursing students.

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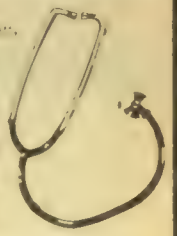
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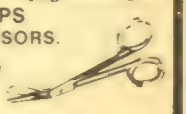
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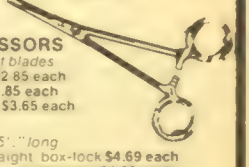
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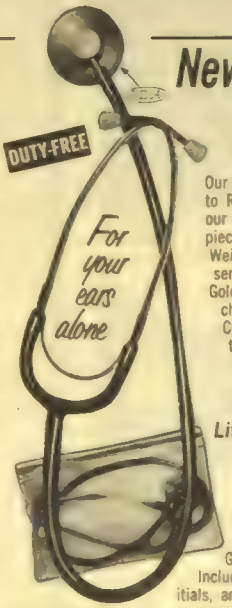
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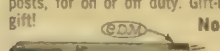
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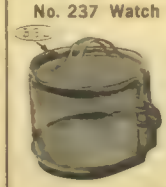
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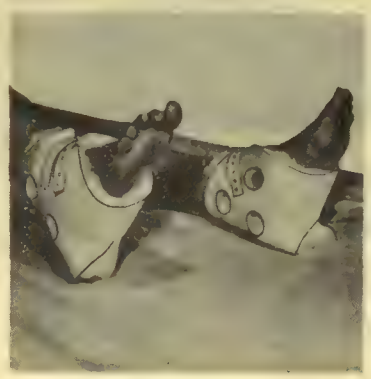
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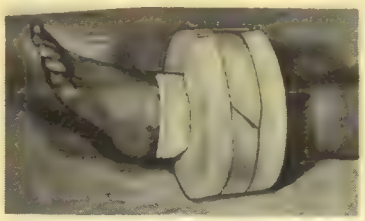
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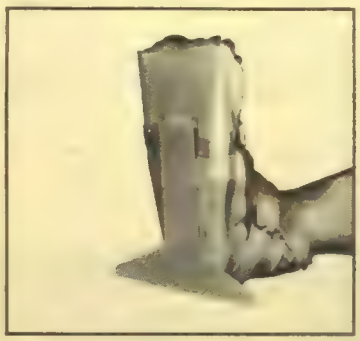




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General Duty Nurses for modern 41-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply: Director of Nursing, Fort Nelson General Hospital, P.O. Box 60, Fort Nelson, British Columbia, V0C 1R0.

General Duty Registered Nurses required by a 100-bed Acute Care and 40-bed Extended Care accredited hospital. Must be eligible for B.C. Registration. Experience preferred. Salary $1122 to $1326 per month, (1976 rates). Apply in writing to the: Director of Nursing, G. R. Baker Memorial Hospital, 543 Front Street, Quesnel, British Columbia, V2J 2K7.

Manitoba

Application is invited for a **sessional faculty position in a curriculum development and evaluation project** for which funding is being sought. Expertise in clinical teaching and curriculum development and evaluation required. Areas of involvement are restorative, ameliorative, conservative, preventive and promotive nursing. Project involves a two year commitment. Salary negotiable. Apply to: Helen P. Glass, Ed. D. Professor and Director, School of Nursing, University of Manitoba, Winnipeg, Manitoba, R3T 2N2.

University of Manitoba — School of Nursing — **Co-ordinator of a Curriculum Evaluation Project** — Nurse with graduate preparation and experience in research, curriculum and teaching, particularly skilled in evaluation, and with administrative abilities to co-ordinate a major curriculum development and evaluation project in a University School of Nursing. Funding is presently being sought for the project which is expected to begin in September 1977 and involves a commitment of five years. For further information write to: Helen P. Glass, Ed.D., Professor and Director, School of Nursing, University of Manitoba, Winnipeg, Manitoba, R3T 2N2.

University of Manitoba — School of Nursing — Applications are invited for positions on the Faculty of a newly initiated, progressive, integrated, health oriented undergraduate nursing program. Subject to budgetary constraints, positions are open for community health nursing and mental health and psychiatric nursing. Expertise in primary health care skills, including health assessment of children, as well as rehabilitative nursing skills, beginning in Fall, 1977. Salary and rank negotiable. Apply to: Helen P. Glass, Ed.D., Professor and Director, School of Nursing, University of Manitoba, Winnipeg, Manitoba, R3T 2N2.

Ontario

Director, Public Health Nursing — Applications are invited for the position of Director, Public Health Nursing in this Health Unit serving 110,000 population. Qualifications: a Master's Degree is preferred, consideration given to a Bachelor's Degree. Applicants must have experience in administration and supervision. Apply in writing to: Dr. Lucy M. C. Duncan, Medical Officer of Health, The Lambton Health Unit, 333 George Street, Sarnia, Ontario, N7T 4P5.

Australia

Qualified Nurse Teacher — Prince Henry's Hospital, St. Kilda Rd., Melbourne, Victoria, Australia — Requires a qualified Nurse Teacher to commence as soon as possible in our school, which has approximately 360 students. Salary and conditions of service in accordance with the Determination of the Registered Nurses' Board. For further details please contact the: Director of Nursing Services, Miss D.J. Taylor at the above address.

Quebec

egistered Nurse required for co-ed children's summer camp in the aurentians (seventy miles north of Montreal) from late June until late ugust 1977. Call (514) 487-5177 or write Camp MaroMac, 5901 leet Road, Hampstead, Montreal, Quebec, H3X 1G9

egistered Nurses — for children's co-ed summer camp. End of une to end of August. Prefer season, will consider one month. /50 00 plus travel. Write: Herb Finkelberg, Director, Jewish ommunity Camps, 5151 Cote St. Catherine Road, Montreal, Quebec, H3W 1M6

United States

ome South! Sunshine, warmth & beaches — mild winters. We epresent hundreds of clients that are seeking Canadian nurses to join eir staff. Third nation entrants need not apply. These situations are aned, and income levels are excellent, up to $14,000 (U.S.) for CU/CCU supervisors; $13,500 for shift supervisors and $12,000 for eneral duty staff nurses. Some situations may require State licenure exam, however, most are available without examination. One ear commitment, round-trip Air Fare, housing assistance and Visa -1 application assistance is provided. Our fee is paid also — you ave no obligation whatsoever. For complete details, send your reume with photograph and full particulars, to: **Medical Search,** 3274 uckeye Road, Atlanta, Georgia 30341.

egistered Nurses — Hurley Medical Center is a well equipped, odern, 600-bed teaching hospital offering complete and specialized ervices for the restoration and preservation of the community's ealth. It also offers orientation, in-service and continuing education r employees. It is involved in a building program to provide better urroundings for patients and employees. We have immediate opeings for registered nurses in such specialty units as Cardio-Vascular, perating Rooms, Nurseries, and General Medical-Surgical areas urley Medical Center has excellent salary and fringe benefits. Beome a part of our progressive and well qualified work force **Today.** pply: Nursing Department, Mr. Garry Viele, Associate Director of ursing, Hurley Medical Center, Flint, Michigan 48502. Telephone 313) 766-0386

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urther your nursing career by gaining experience at the largest eaching and acute care referral center in Texas. This medical omplex consists of 7 hospitals and 1200 beds, and offers you a broad hoice of nursing specialty and sub-specialty areas in which to work. ou'll live on semi-tropical Galveston Island (50 miles from Houston), ith 32 miles of sandy beaches bordering the Gulf of Mexico. Enjoy oderate temperatures all year long and a low cost of living. Contact: ary Clark, Asst. Director, Dept. of Nursing, The University of Texas edical Branch, Galveston, Texas 77550. An equal opportunity F/M ffirmative Action Employer.

Red Deer College

invites applications for faculty positions in the **Diploma Nursing Program.**

Preference given to applicants with advanced preparation and clinical specialization, who have proven ability in the teaching of Nursing.

Positions available August 1, 1977.

Please forward application, comprehensive curriculum vitae and references to:

Dr. Gerald O. Kelly
Academic Dean
Red Deer College
Box 5005
Red Deer, Alberta, Canada
T4N 5H5

Associate Executive Director

Applications are invited for the position of Associate Executive Director, Canadian Nurses Association, Ottawa.

Candidates must be members of the Canadian Nurses Association, have a master's degree or equivalent, have at least five years' administrative experience, and be bilingual.

Interested applicants are asked to submit their curriculum vitae, in confidence, to:

Executive Director
Canadian Nurses Association
50 The Driveway
Ottawa, Ontario
K2P 1E2

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Assistant to the Director for Staffing
Department of Nursing
UNIVERSITY HOSPITAL
University of Kentucky
Lexington, Kentucky 40506

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Address _____
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Date of Graduation _____

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FACULTY OF NURSING
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Faculty members will be required for positions in expanding four-year basic and two-year post-R.N. baccalaureate programs. Applicants should have graduate education and experience in a clinical area and/or in curriculum development or research.

Short-term or visiting appointments may also be available in some areas to replace staff on leave.

Salary and rank commensurate with qualifications and experience, in accord with University policies.

Positions are open to male and female applicants.

Please make further inquiries, or submit application and curriculum vitae to:
Amy E. Zelmer, Ph. D.
Dean
Faculty of Nursing
The University of Alberta
Edmonton, Alberta
T6G 2G3

Okanagan College
NURSING FACULTY REQUIRED

Okanagan College is establishing the second year of a new Diploma Nursing Program. Applications are invited for instructional positions. Four appointments will be made in the Spring of 1977; a fifth appointment will be made at the end of the year.

Duties:
Classroom and clinical instruction; curriculum development; other duties as assigned by the Coordinator of Nursing Education. Instructors will be required to travel to nearby communities.

Qualifications:
Master's Degree preferred; Bachelor's minimum. Teaching experience desirable; at least two years' clinical experience essential.

Salary and working conditions in accordance with the Academic Faculty Agreement.

Applications and information:
The Principal
Okanagan College
1000 KLO Road
Kelowna, B.C. V1Y 4X8

Closing date: March 15, 1977.

The Montreal Children's Hospital

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Our patient population consists of the baby of less than an hour old to the adolescent who has just turned seventeen. We see them in Intensive Care, in one of the Medical or Surgical General Wards, or in some of the Pediatric Specialty areas.

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If you do not like working with children and with their families, you would not like it here.

If you do like children and their families, we would like you on our staff.

Interested qualified applicants should apply to the:

Director of Nursing
Montreal Children's Hospital
2300 Tupper Street
Montreal, Quebec, H3H 1P3.

Applications are invited from suitably qualified candidates for the post of **Nurse Tutor** in the University of Nigeria Teaching Hospital, Enugu.

Qualifications and Experience
Candidates should be Registered Nurse Tutors. Previous teaching experience is an advantage. The appointee will teach general nursing subjects for new standard of nurse training.

Salary:
(Grade Level 08, N3,264 — N4, 164)

Conditions of Service
Conditions of service are similar to those in the Federal Public Service — passages for appointee and family fringe benefits including pensions scheme, leave car allowance, part-furnished accommodation or rent supplement at the approved rate in lieu, and free Medical services.

Method of Application
Full curriculum vitae and names and addresses of 3 referees to:
Ag. Director of Administration
University of Nigeria Teaching Hospital
P.M.B. 1129
Enugu, Anambra State, Nigeria

Closing Date: March 1977.

Director of Nursing

Dryden District General Hospital

Dryden District General Hospital is a 75 bed accredited hospital located in the Town of Dryden, population 7,000, area served 15,000. Dryden is midway between Winnipeg and Thunder Bay on the Trans-Canada highway in the midst of the Patricia Tourist Region. Transair provides twice daily jet flights to Toronto and Winnipeg.

Many cultural and recreational opportunities are available to residents of and visitors to the community.

Experienced applicants with a university degree will be given preference but experience in a supervisory capacity in a larger hospital will receive consideration. Employees benefits are generous, salary is negotiable. Employment is available immediately.

Please write or telephone to:

Administrator
Dryden District General Hospital
Dryden, Ontario Phone: 807-223-5261

THE COLLEGE OF NEW CALEDONIA

Prince George, British Columbia

requires

NURSING FACULTY

A number of positions will be available beginning in 1977 for qualified faculty to participate in a new Diploma Nursing Program scheduled to commence September, 1977.

Preferred Qualifications:

— A Baccalaureate degree and registration, or eligibility for registration, with the Registered Nurses Association of B.C.

— A minimum of two years nursing practice or relevant teaching experience.

Applications presently on file will be considered.

We offer excellent salaries and a complete fringe benefit package.

To apply: Sumbit a complete resume together with the names of three references to:

Dr. F.J. Speckeen, Principal
The College of New Caledonia
2001 Central Street
Prince George, B.C. V2N 1P8

Extension Course in Nursing Unit Administration

Applications are invited for the extension course in Nursing Unit Administration, a program to help the head nurse, supervisor or director of nursing up-date his or her management skills. Candidates will be registered nurses or registered psychiatric nurses employed in management positions on a full-time basis.

The program provides a seven month period of home study with two five day intramural sessions, one preceding and one following the home study. For the 1977-78 class the initial intramural sessions will be held regionally as follows:

Vancouver	August	22	— 26
St. John's (Nfld.)	August	29	— September 2
Winnipeg	August	29	— September 2
Montreal (French)	August	29	— September 2
Hamilton	September	12	— 16
Ottawa	September	12	— 16
Toronto	September	19	— 23

Early application is advised. Applications will be accepted until *May 16, 1977*, if places are still available at that time. After acceptance, the tuition fee of $275.00 is payable on or before July 1, 1977.

The program is co-sponsored by the Canadian Nurses Association and the Canadian Hospital Association and is available in French or in English.

For additional information and application forms write to:

English Program:
Director
Extension Course in Nursing Unit Administration
25 Imperial Street
Toronto, Ontario
M5P 1C1

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Positions are available at nursing stations, health centres and hospitals for the period, May through September.

Knowledge of the English language is essential.

NOTE: Permanent positions are also available

For more information, clip and mail the coupon below to:

Personnel Administrator
Medical Services
Northwest Territories Region
Health and Welfare Canada
14th Floor, Baker Centre
10025 - 106th Street
Edmonton, Alberta T5J 1H2
or call collect: (403) 425-6787

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For more information, please contact:

CUSO Health — 12
151 Slater Street
Ottawa, Ontario
K1P 5H5

Dr. Helmcken Memorial Hospital Clearwater, B. C.

Director of Nursing for a 20-bed general hospital located 70 miles north of Kamloops, B. C.
To be responsible for all aspects of nursing care and the day to day operation of the hospital, reporting to area administration at Royal Inland Hospital, Kamloops, B. C. Must be eligible for B. C. registration with previous administrative experience and preferably with advanced preparation.
Salary negotiable with generous fringe benefits.

Apply to:
Personnel Director
Royal Inland Hospital
Kamloops, B. C. V2C 2T1, Canada

University Faculty

Applications are invited for the position of Assistant or Associate Professor of Community Health Nursing in a basic University program enrolling approximately 200 students.

A Master's degree and expertise in practice are required. Preference given to candidates with graduate preparation and/or experience in Maternal Child Nursing. Teaching experience in a university program is desirable. Candidate must be eligible for registration in Ontario.

Salary commensurate with qualifications.

Apply in writing giving curriculum vitae to:
Dr. E. Jean M. Hill
Dean and Professor
School of Nursing
Queen's University
Summerhill
Kingston, Ontario K7L 3N6

Clinical Specialist Nursing

We require the services of an articulate, dynamic nurse with a Master's Degree and a Major in Medical-Surgical nursing.

We are a 300 bed Hospital Complex on the verge of a major expansion. We are close to fine recreational and cultural areas.

The nurse in this position will work closely with our Medical Staff, Administrative Staff and Staff Nurses to further develop patient centered projects. The salary and benefits are based on the qualifications and experience of the applicant.

For further information about this opportunity, please forward a complete resume to:
Director of Personnel
Red Deer General Hospital
Red Deer, Alberta
T4N 4E7

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THE IZAAK WALTON KILLAM HOSPITAL FOR CHILDREN
Halifax, Nova Scotia
B3J 3G9

Head Nurse

with preparation and/or demonstrative competence in **Psychiatric Nursing and Management** functions, required for Head Nurse appointment. To be responsible for participation in the organization, initiation, and the management of a **New Psychiatric In-patient Unit.**

Please apply, forwarding complete resume to:
Director of Personnel
Stratford General Hospital
Stratford, Ontario
N5A 2Y6.

Port Saunders Hospital requires **one Registered Nurse** commencing May 1977 through to October 1977.

Applicants must be registered or eligible for registration with the Association of Registered Nurses of Newfoundland.

Salary is on the scale of $9,963 to $12,282.
Living-in accommodations available for single applicants.

Applications should be addressed to:
Mrs. Madge Pike
Director of Nursing
Port Saunders Hospital
Port Saunders, Newfoundland
A0K 4H0

Head Nurse

The Position:
Directing an active 40 bed surgical unit with opportunity for future advancement.

The Person:
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The Hospital:
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Please send complete resume to:

Director of Personnel
Red Deer General Hospital
Red Deer, Alberta
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General Hospital St. John's Newfoundland

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General Hospital
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St. John's, Newfoundland
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Address application and completed curriculum vitae to the:
Director of Personnel
JOHN ABBOTT COLLEGE
P.O. Box 2000
Ste. Anne de Bellevue, Quebec H9X 3L9

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invites applications for the position of

EXECUTIVE DIRECTOR

This position entails managing the affairs of the 7200-member association. Duties include participating in the development and implementation of policy, budgeting and financial management, communication with groups and individuals. The successful applicant will have over-all responsibility for a staff of 12, and will answer directly to the association's governing council.

Salary: Negotiable.

Qualifications: Applicants must have a master's/baccalaureate degree with a major in administration, several years' experience in an administrative position or related experience, and be eligible for registration with the Saskatchewan Registered Nurses' Association.

Applications, giving full details of education, qualifications and experience, should be sent to:

Mrs. Sheila Belton
Chairman, Selections Committee
59 Empress Drive
REGINA, Saskatchewan
S4T 6M7

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For further information on any, or all, of these career opportunities, please contact the Medical Services office nearest you or write to:

Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

Name

Address

City Prov.

Health and Welfare Canada | Santé et Bien-être social Canada

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Interested candidates are required to have the managerial ability to work with all levels of nursing, administration and medical staff.

MINIMUM QUALIFICATIONS:
Must be currently registered in the Province of Ontario. Preference will be given to candidates with additional educational preparation and experience in nursing management.

Resumes should be sent to:
Mr. R. E. Capstick
Manager, Employment & Staff Relations
McMaster University Medical Centre
1200 Main Street West
HAMILTON, Ontario
L8S 4J9

Dalhousie University
School of Nursing

FACULTY VACANCIES

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Applications and further information may be obtained from:

Dr. Margaret Scott Wright
Professor and Director
School of Nursing
Dalhousie University
Halifax, Nova Scotia
B3H 4H7

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C I B A
Dorval, Quebec

the canadian nurse

March 1977

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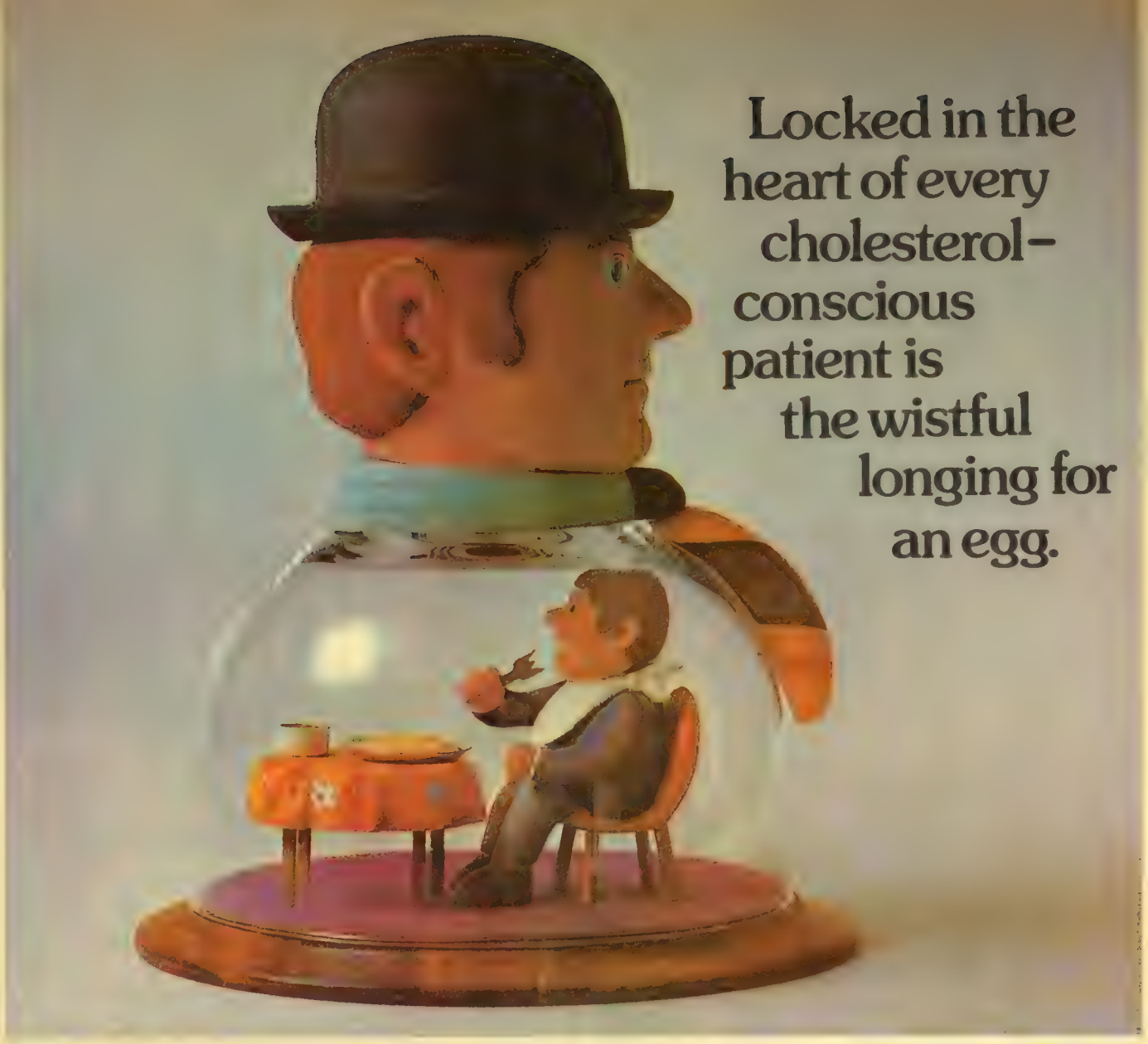
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the canadian nurse

March, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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The pins on this month's cover are from CNA's collection of nursing school pins on permanent display in the Archives at CNA House. The collection began ten years ago with donations from the estates of two former CNA members and has grown since then to include the 16 pins pictured on the cover. The Association is anxious to expand its collection to include a more representative selection from both existing and former schools of nursing. If you would like to see your school represented, please contact the Librarian, CNA House. For identification of pins, see page 4. (Photo by Studio Impact).

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

Is nursing in Canada going through an identity crisis? One that affects 130,000 practising nurses and thousands of young people who hope to follow in their steps? One that troubles employers as well as educators, and recipients, as well as providers of health care?

Over the past 12 months, I have listened to many leaders of the nursing profession as they talked to their fellow nurses in groups across this country. I have come away from these meetings convinced that in order to consolidate the gains they have made in the first half of this century in the advancement of the profession, nurses are going to have to find some way of reaching a concensus on some very basic questions ... questions like what it is that they do and who it is that makes the decisions and accepts responsibility for their actions.

Certainly, nursing does not stand alone in facing this threat to its identity ... if it is a threat. All of the professions, but particularly the health professions, are presently undergoing what has been called a "crisis of public confidence" that is forcing them to take a long, hard look at how close they actually come to meeting the real needs of society today.

Inevitably, however, it is criticism of the nursing profession and questions about nursing and nursing care that concern us most closely and immediately.

What does it mean, for example, when the majority of nurse/respondents to a survey on quality of care in the United States and Canada describe the care they see around them as "low grade B"?

What is our own reaction to the challenge of rising consumer expectations when we are faced with budget constraints and administrative decrees that leave us with neither the time nor the energy to think of the patient as a person who depends on us to help him achieve his goal of "health"?

Is it true that the nurse is becoming a "jack-of-all-trades and master of none" and, if it is, what can we do about it?

Are we really in danger, as one nurse/educator claims, of losing our essential caring quality and, in fact, our sense of the *wholeness* of nursing?

In this issue of CNJ, three nurses who have worked within a primary nursing set-up, describe the difference this makes to their perception of their role within the health care system. For them, the "one nurse, one patient, planning care together approach" and the responsibility that this entails makes it a little easier to answer the fundamental question that all nurses are faced with now: "Who am I, what am I doing here, and where am I going?"

— **M.A.H**

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How do *you* feel about growing older — as an individual or as a nurse who cares for our older people? **Next month,** CNJ explores the subject of aging as it involves nursing and you. We'll look at what goes on in a day hospital in Edmonton, Alberta, a nursing home in Hamilton, Ontario, and a geriatric center in Toronto, among other places, and talk about some practical ways that nurses can help to make the last of life a little better for these important people.

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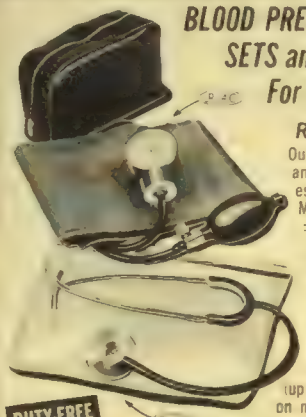
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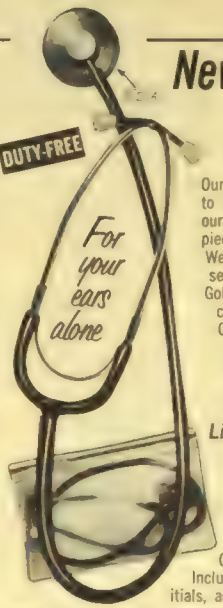
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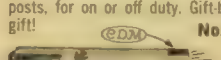
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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

The quality of our caring

Thousands of cancer patients must now present themselves, usually in a teaching hospital, for review and treatment on a regular basis. As controls improve, many of us are living much longer than expected and must be considered "problems" by professional staff — secretaries, technicians, nurses, and doctors. We flood existing facilities at all levels and place a great strain on too few hematologists and oncologists.

I am myself a chronic patient, beginning my fifth year of therapy in two centers — one for cobalt, one for chemo. I am concerned about what is happening to me and to others like myself. Somehow, in the treatment of some incurable diseases, when patients *must* be treated or they will die, "Equal Rights" has come to mean "Everyone is the Same." When this happens, individual identity is lost: the patient becomes a *nonentity — a cipher— a case.*

Some questions arise:

Why must patients endure several inept attempts to draw blood, or insert I.V.'s?

Who decided that patients have hours to waste in crowded waiting rooms, waiting for tests or to see their doctors? Why are they not seen or treated on an appointment basis?

Why are patients' names called on a P.A. system, or bellowed by a staff member without courtesy of a title?

Why are they herded in groups, sometimes undressed, from one place to another?

Does the patient know the name of the doctor responsible for his care? How often does he see that doctor?

Is the patient required to submit to examination by a different doctor each time? What happens if he refuses such examination?

Is the patient threatened in any way?

What does a patient, being treated as an out-patient, do when he has a bad reaction, calls his doctor's office for advice, and is told the doctor does not speak to patients on the telephone?

Who decided it is better for patients, admitted for therapy, to share rooms, bathrooms, even a whole floor with other cancer patients? Perhaps, it is better for the staff? Is a patient entitled to any privacy? Who answers his questions if he never sees his doctor alone? How does the patient who is lying in bed feel, when a group standing around, discusses him as if he were non-existent?

We patients know some of the answers to these questions and appreciate at least some of the problems that are encountered in our care. But, again, the question arises — how many of the answers are merely excuses?

It does seem to me that the patient is caught in a rapidly developing atmosphere of indifference, intimidation, and coercion. Most certainly we need medical care for our future generations, but it distresses me to think that my children and grandchildren may endure the added anxieties and frustration that attend what, at its best, must be called difficult therapy.

Perhaps patients might be asked for suggestions as to their needs or preferences.

Perhaps the time has come for patients to teach attending staff, by expressing their thoughts regarding attitudes and treatment at all levels.

Perhaps the time has come, too, for attending staff to be reminded that patients are individuals — they do have feelings and are entitled to courtesy and respect.

— M.E. Murray, Toronto, Ontario.

Paraplegics revisited

In the December issue of *The Canadian Nurse* the article "Towards Independence for Paraplegics" had two minor errors. On page 25, the brace (upper photo) is a Jewitt *Hyperextension* brace, not hypertension brace.

The other is on page 27, middle of page, when mentioning the radiological examination of a dynamic voiding cysto-urethrogram to determine the cause of bladder dysfunction, be it due to spasm of the external sphincter, urethral strictures, bladder calculi or *reflux.* A reflux, if present, is seen during this examination, but is a complication of bladder training, rather than a direct cause of dysfunction, as are the other mentioned factors.

— Ane Marie Hansen, R.N., Toronto, Ontario.

Brash, pretentious, abrasive?

My response to your invitation to comment on the topic of M.A. Wickham's letter (December, 1976) follows.

It was with some surprise that I realized that the June, 1974 resolution to omit titles such as Miss or Mrs. in all CNA communications would result in only the surname of an individual being used.

This practice creates a harsh and abrasive tone.

Would it not be more appropriate to refer to the individual by his/her first name?

— Mardy Brown, Gulf Station, South Hazelton, B.C.

The practice of referring to nursing professionals with "bare" surnames communicates a kind of brash pretentiousness. The use of surnames only calls forth a reaction of both physical (cringing) and emotional dimension. Why not use the person's first name or title appropriate to their status? This practice was popular in early nursing-training experience when one's best friends found the title "Miss" cumbersome while working in patient-care areas. Perhaps the use of the "bare surname" conjures up reflections of the driving work ethic during a period of experience (utility rooms, waste baskets, maps and dusting) which many would prefer to forget.

I find it unattractive in our literary journal.

— Thelma Potter, Reg. N., Toronto, Ontario.

I, too, abhor the use of bare surnames in *The Canadian Nurse.* I thought initially that I would gradually adapt to this, however, this has not yet happened. It seems such a paradox when we talk about personalizing care for our patients; yet, our professional journal addresses individuals in this coldly impersonal manner.

— Bonnie Hartley, Graduate Student, Faculty of Nursing, University of Western Ontario.

Abortion counselling

I was very pleased to read the article "Abortion Counselling" by Bonnie Easterbrook and Beth Rust *(January, 1977).*

Canadian hospitals have been avoiding their responsibility of providing abortion services. Statistics Canada lists 258 hospitals, out of 1,359 in Canada, with Therapeutic Abortion Committees. A 1975 survey conducted by the Doctors for Repea of the Abortion Law (DRAL) shows that only one-third of Canadian hospitals that are technically equippec to perform abortions are listed as having such a committee. The overdue report of the government funded Badgley Commission which is investigating the application of the present abortion law in Canadian hospitals should provide more curren data.

Abortion counselling by competent personnel is an essential health service which more hospitals should provide. Sensitive, concernec nurses can expand their role into this important health care area. Please keep us informed of current developments.

— Linda Ratcliffe, Reg. N., C.P., London, Ontario.

Long-term care for RN's

The December 1976 issue of *The Canadian Nurse* has an announcement in the "News" colum of Canada's "first" extended care program for registered nurses at Grant MacEwan College in Edmonton, Alberta.

Our program here at Centennia College in Scarborough, Ontario, entitled "Certificate of achievement fo registered nurses in Long-Term Care' has been in operation now for almos two years, and was approved by the Council of Regents of our provincial Ministry of Colleges and Universities Those of us involved with the formation, development and implementation of the program feel that it meets a real need, and we are delighted to see other colleges develop programs of similar nature.

— Patricia Prentice, Coordinator of Applied Arts/Academic/ Health Programs, Continuing Education Division, Centennial College of Applied Arts and Technology, Scarborough, Ontario.

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- more information on nursing management of fluid and electrolyte problems;
- the section on sexual role satisfaction contains new information on assessment techniques in breast cancer and venereal disease along with client instruction techniques. A new section on rape considers prevention and treatment;
- additional learning aids; more than 100 new illustrations plus additional assessment guides and summary tables.

By Janet Miller Barber, R.N., M.S.; Lillian Gatlin Stokes, R.N., M.S.; and Diane McGovern Billings, R.N., M.S. March, 1977. Approx. 1,024 pages, 8" × 10", 738 illustrations. About $18.85.

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A New Book! ELEMENTS OF REHABILITATION IN NURSING: An Introduction. *By Rose Marie Boroch, R.N., M.A.; with 4 contributors.* This dynamic new book approaches the theory and practice of rehabilitation from a psychosocial perspective. Contributions by specialists in community health, orthopaedic rehabilitation, and sexual function stress ways to meet the physical, emotional, and social needs of the rehabilitating patient. Informative discussions offer new insights on the health care environment; physical and psychosocial functions in health related therapies; and application of the nursing process. September, 1976. 328 pp., 60 illus. **Price, $8.95.**



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A New Book! NURSING MANAGEMENT OF DIABETES MELLITUS. *Edited by Diana W. Guthrie, R.N., M.S.P.H., F.A.A.N. and Richard A. Guthrie, M.D., F.A.A.P.; with 9 contributors.* This important new text presents up-to-date information to help the nurse better understand diabetes mellitus — and to properly educate diabetic patients. Emphasizing the care of the aged and children with diabetes, the authors discuss diagnosis, nursing management, acute and chronic care, complications, special problems, and patient education. Psychosocial aspects are examined in depth. March, 1977. Approx. 240 pp., 64 illus. **About $7.30.**

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Volume I! CURRENT PERSPECTIVES IN NURSING EDUCATION: The Changing Scene. Edited by Jane A. Williamson, Ph.D., R.N.; with 18 contributors. 1976, 188 pages plus FM I-X, 6¾″ × 9¾″, 12 figures. Price: $11.05 (C); $7.90 (P).

Volume I! CURRENT PRACTICE IN ONCOLOGIC NURSING. Edited by Barbara Holz Peterson, R.N., M.S.N. and Carolyn Jo Kellogg, R.N., M.S.; with 27 contributors. 1976, 230 pages plus FM I-XVI, 6¾″ × 9¾″, 3 illustrations. Price: $11.05 (C); $7.90 (P).

Volume I! CURRENT PRACTICE IN PEDIATRIC NURSING. Edited by Patricia A. Brandt, R.N., M.S.; Peggy L. Chinn, R.N., Ph.D.; and Mary Ellen Smith, R.N., M.S.; with 15 contributors. 1976, 242 pages plus FM I-XIV, 6¾″ × 9¾″, 13 illustrations. Price: $11.05 (C); $7.90 (P).

Volume I! CURRENT PERSPECTIVES IN PSYCHIATRIC NURSING: Issues and Trends. Edited by Carol Ren Kneisl, R.N., Ph.D. and Holly Skodol Wilson, R.N., Ph.D.; with 24 contributors. 1976, 228 pages plus FM I-XIV, 6¾″ × 9¾″, 9 figures. Price: $11.05 (C); $7.90 (P).

Volume I! CURRENT PRACTICE IN OBSTETRIC AND GYNECOLOGIC NURSING. Edited by Leota Kester McNall, R.N., M.N. and Janet Trask Galeener, R.N., M.S.; with 19 contributors. 1976, 254 pages plus FM I-XVI, 6¾″ × 9¾″, 39 illustrations. Price: $11.05 (C); $7.90 (P).

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News

MARN representatives meet with cabinet

The Board of Directors and other representatives of the Manitoba Association of Registered Nurses met with Premier Ed Schreyer and members of his Cabinet in mid-January, to present recommendations on matters of concern to the Association. The meeting was the first to take place between MARN and representatives of the government of that province.

A brief presented by MARN stressed the Association's desire for a continued and regular liaison with government in matters related to health care, particularly as such matters affect the delivery of nursing care.

The purposes and objectives of the Association were outlined with a discussion of the ways in which MARN is carrying out its objectives. For example: registration of members, a referral service to assist both nurses seeking employment and employers, a program presently in progress to establish standards of nursing practice, continuing education, refresher course programs, promotion of inservice education, bursaries and loans to assist nurses in further education, consultation and funds to assist in nursing research projects were mentioned.

Brief reference was made to the Association's Position Paper on Nursing Education: "Challenge and Change." Concern was again expressed that only one member from MARN was permitted to be on the Ministerial Task Force appointed to recommend on nursing education.

Resolutions passed at the Association's annual meeting were also referred to the Cabinet for consideration. These dealt with learning resource centers for health workers; support of non-smoking programs and discouraging the sale of tobacco in health agencies; legislation for compulsory use of seat belts, crash helmets, and reduction in speed limits.

The Association stressed the urgent need in Manitoba for nurses prepared at the Master's level and strongly urged government support for the immediate establishment of a M.Sc.N. program at the University of Manitoba.

CNA research study reveals few key changes in nursing employment, education patterns since 1966

The research unit of the Canadian Nurses Association has released the results of a review of trends in the growth and expansion of the nursing profession in Canada between 1966 and 1974.

Highlights of the study, according to research officer, Marion Kerr, include the following:

- Between 1966 and 1974, the number of registered nurses employed in nursing increased by 56 percent (from 82,517 in 1966 to 128,675 in 1974).
- the field of employment and the education levels of nurses working during this period did not vary significantly from those of the previous decade.

Increased public and popular emphasis on preventive and maintenance health services provided from community-based agencies and the need for higher levels of education to prepare nurses to work in these settings were not reflected in actual practice. **In 1974 (as in 1966) more than 80 percent of employed registered nurses working in Canada worked in hospital/institutional settings; more than 80 percent had as their highest academic preparation the diploma leading to an R.N.**

Other highlights of the study:

- the percentage of registered nurses employed in community health settings remained relatively stable;
- the greatest shift in level of education, a dramatic one from diploma leading to R.N. to baccalaureate degree, occurred among registered nurses employed in nursing education;
- the number of registered nurses and the number of those holding the baccalaureate degree both increased by 56 percent;
- the level of education for registered nurses employed as directors and assistant directors of nursing declined;
- levels of education for registered nurses employed as supervisors and head nurses and as general duty/staff nurses rose slightly.

Four questions about the employment settings and educational preparation of nurses in the period between 1966 and 1974 were investigated :

Q. Was there a shift towards a larger percentage of registered nurses being employed in community health nursing?

A. Rather than a shift towards employment in community health settings, there was actually a 1.4 percent decline in the percentage of registered nurses employed in community health settings. It seems clear that although the actual number of registered nurses working in community health settings did increase, the expansion of hospitals and other institutions continued to absorb the majority of registered nurses during this period.

Q. Was there a shift towards higher levels of education for employed nurses?

A. While very little shift occurred between 1966 and 1974 in level of education of employed registered nurses, what shift did occur was away from the diploma leading to R.N. towards the baccalaureate degree. In both 1966 and 1974 over four-fifths of employed registered nurses had as their highest academic preparation the diploma leading to R.N. While there was an increase of 2.7 percent in the group holding the baccalaureate degree, there was little change in the group holding the master's or higher degree and little change in the group holding some credits towards a baccalaureate degree.

Q. Were there shifts in level of education towards greater preparation for registered nurses employed in community health settings?

A. The greatest shift in level of education did not occur in the group of registered nurses employed in community health settings, but rather in the group employed in nursing education. Between 1966 and 1974, the most prevalent level of education for nurse teachers shifted from diploma leading to R.N. (29.4 percent in 1966) to baccalaureate degree (60.6 percent in 1974). In the same period the percentage with a master's or higher degree more than doubled from 5.9 percent to 13.9 percent. The second largest shift occurred in the group of registered nurses employed in community health settings where the percentage of those holding the baccalaureate degree approximately doubled (as it did in all three fields of employment).

Q. Was there a shift towards higher levels of education among registered nurses employed in administrative and managerial positions,* in general duty, and in nursing education?

A. The greatest shift, an upward one, occurred among the group of nurse teachers, 60.6 percent of whom held a baccalaureate degree in 1974, compared to 25.7 percent in 1966. Among directors and assistant directors of nursing there was a downward shift in level of education. There was an *upward* shift in the level of education of supervisors and head nurses and the level of education of the general duty/staff nurse group also shifted upwards slightly.

* Note: *For the purpose of this review administrative and managerial positions comprise the positions of director and assistant director of nursing, and supervisor and head nurse.*

Did you know ...

At a meeting held recently in Montreal to form the **Practitioners of Infectious Control** in Canada, one of the recommendations was the formation of local interest groups. One such group is forming in the Prairies. If you are interested in this field, please contact: Laura Black/Jean Harper, Continuing Medical and Nursing Education, The Plains Health Centre, 4500 Wascana Parkway, Regina, Sask., S4S 5W9.

Table 1: ***Registered Nurses Employed in Nursing in Canada by Field of Employment, 1966 and 1974.***

Field of Employment	1966	1974
Hospital/other institution	80.1	83.8
Community health agencies[1]	11.4	10.0
Nursing education programs	3.6	2.8
Other[2]	4.9	3.4
Total	100.0%	100.0%
	(n= 82,517)	(n = 128,675)

1. Community health agencies include public health, school health, occupational health, physician's and/or dentists' office.
2. Other includes private duty and other specified fields.

Table 2: ***Registered Nurses Employed in Nursing in Canada by Highest Level of Education, 1966 and 1974.***

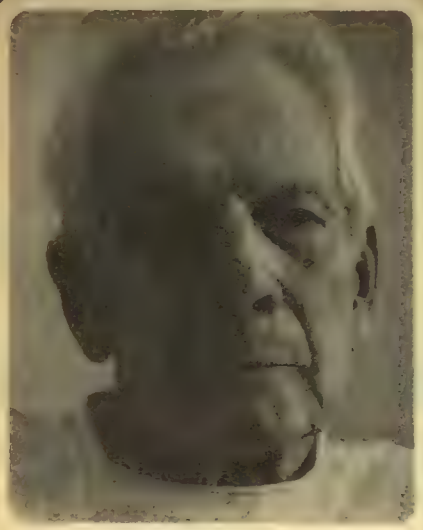
Highest Level of Education	1966	1974
Diploma leading to R.N.	85.2	82.0
Some credits towards a baccalaureate degree	9.5	9.9
Baccalaureate degree	4.8	7.5
Master's or higher degree	0.5	0.6
Total	100.0%	100.0%
	(n = 82,517)	(n = 128,675)

Table 3: ***Registered Nurses Employed in Nursing in Canada, by Highest Level of Education and Field of Employment, 1966 and 1974.***

Highest Level of Education	Hospital/other institutions		Community health agency		Nursing education programs	
	1966	1974	1966	1974	1966	1974
Diploma leading to R.N.	88.8	86.4	72.8	59.4	39.9	11.2
Some credits towards a baccalaureate degree	7.8	8.1	17.9	23.9	24.8	14.3
Baccalaureate degree	3.2	5.3	8.6	16.0	29.4	60.6
Master's or higher degree	0.2	0.2	0.7	0.7	5.9	13.9
Total	100.0% (n = 66,172)	100.0% (n = 107,769)	100.0% (n = 6,834)	100.0% (n = 12,844)	100.0% (n = 2,932)	100.0% (n = 3,427)

Table 4: ***Registered Nurses Employed in Nursing in Canada by Highest Level of Education and Position, 1966 and 1974.***

Highest Level of Education	Directors and Assistant Directors of Nursing		Supervisors & Head Nurses		General Duty/ Staff Nurses		Nurse Teachers	
	1966	1974	1966	1974	1966	1974	1966	1974
Diploma leading to R.N.	60.1	62.6	84.3	78.8	88.4	86.2	42.7	11.2
Some credits towards a baccalaureate degree	15.2	14.7	11.4	13.7	8.2	8.5	27.5	14.3
Baccalaureate degree	19.3	18.0	4.1	7.1	3.3	5.3	25.7	60.6
Master's or higher degree	5.4	4.7	0.2	0.4	0.1	0.1	4.1	13.9
Total	100.0% (n = 2,549	100.0% (n = 3,735)	100.0% (n = 14,894)	100.0% (n = 21,207)	100.0% (n = 54,906)	100.0% (n = 96,793)	100.0% (n = 3,053)	100.0% (n = 4,720)



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News

CNA Directors hold Work Session to consider nursing directions

Directors of the Canadian Nurses Association have come up with a list of five major recommendations for action by the nursing profession. The list includes a recommendation concerning the development of a definition of nursing practice.

The recommendations were approved at a special Work Session called by CNA Directors to discuss "Regulation of the Profession: Nursing Directions — Power and Purpose." The session took place in Ottawa in mid-January and was attended by members of CNA's Board of Directors and advisers to the Directors.

CNA president Joan Gilchrist, who was chairman of the session, noted that directors had agreed at their last meeting of the Board that regulation of the profession must be considered a priority throughout the 1976-78 biennium and had expressed concern over the fact that the control and delivery of nursing services were being shaped by people outside the nursing profession. They had expressed the desire to meet to gain first-hand information on what was happening in nursing and health services across the country so that they could identify problems, propose strategies and identify ways that CNA could assist in solving these problems. During the work session a representative from each of the eleven provincial territorial member associations made a verbal presentation identifying issues and concerns within their region.

The five recommendations approved were:

- that a definition of nursing practice be developed.
- that the Executive Committee (a) review the CNA Position Statements and CNA Publications in the light of issues discussed, (b) make necessary revisions or proposals, and (c) report back to the next Board of Directors meeting.
- that a discussion paper be prepared on principles, alternatives, implications and strategies related to registration/licensure by the provincial nurses' associations.
- that the two consultants in Labor Relations Services give priority to preparation of a draft statement for the Executive Committee outlining the role of union *vis a vis* the role of the professional association.
- that the Executive Committee study the feasibility of initiating a draft paper on the delivery of health care services with a view to developing a statement on the delivery of nursing services independently and in conjunction with professionals and others in the health care system; that the Executive Committee use CNA members and/or consultants to obtain needed data and that current CNA papers in delivery of service and related documents be utilized; that projections for future delivery of nursing services be included.

MARN supports Alert

A recent demonstration of Heart Alert (Heart and Lung Emergency Resuscitation Training) was enthusiastically received by the Manitoba Association of Registered Nurses' Board of Directors and presidents of MARN Chapters. The Heart Alert demonstration, presented at a recent Board meeting by Eleanor Wilson and Dr. W.A. Tweed, teaches people to deal effectively with cardiac emergencies by education in coronary risk factors, recognition of the signals of heart attack, emergency action for survival, cardiac first aid, and training in cardio-pulmonary resuscitation for hospital and community emergency rescue personnel.

The program is sponsored by the Manitoba Heart Foundation and has received the support of many of the health care disciplines. Follow-up cases show that lives have been saved through emergency cardiac first aid, administered by persons trained in the advanced techniques of this lifesaving program. In order to bring information about this program to its members, MARN is planning meetings at chapter, district, and provincial levels.

UWO Dean of Nursing addresses Seneca College Education Day

Nurses in Canada are going to have to make some tough decisions in the next few years in order to continue to grow and develop as a profession and to meet the expectations of both employers and consumers of health care. The decade coming up, according to Josephine Flaherty, Dean of the Faculty of Nursing at the University of Western Ontario is one of decision and it is up to nurses to meet this challenge from within the profession. "Nurses hold the future of nursing in their hands," she says.

Flaherty, who was addressing more than 200 nurses on the occasion of Education Day at Seneca College of Applied Arts and Technology in Toronto, paid tribute to the accomplishments of nursing leaders during the last fifty years. As a result of their efforts, she said, nurses in Canada show a new level of maturity and are better prepared than ever before to participate in the decision-making that will be required. She called on nurses as a group to prepare themselves for peer review since "a profession monitors its own members" and "we as nurses are the experts in the practice of nursing."

"Many nurses," she pointed out, "are allowing their practice to be controlled by the expectations of others, including members of the medical profession and administrators in the hospital and educational setting. As nurses, we must define nursing practice and develop and implement ways of recognizing excellence in that practice among our own members."

Often, according to Flaherty we, accept the principle of maintaining competency without recognizing it as "a way of life." She described compulsory continuing education as neither philosophically acceptable nor practical at this time in Ontario but pointed out that it is only by making a voluntary commitment to continuing education that an individual can encourage and assess his own needs, explore available resources, develop and grow to meet the challenges of a dynamic profession.

Flaherty is a past president of the Registered Nurses Association of Ontario and a former member of the Board of Directors of the Canadian Nurses Association. Her address set the tone for the six work sessions that were also featured on the program for Education Day at Seneca College Nursing Division. The event, which was first held in 1968, is an annual affair, open to nurses from all the hospitals and community agencies where Seneca College nursing students obtain their clinical experience. Donna Wells, Chairman of the Nursing Division, describes it as "one way of helping to bridge the gap between education and service."

Discussion leaders for the 1977 Education Day included: Primary Nursing — Gail Ouellette, North York General Hospital; Pat Kearns, Sunnybrook Hospital; Pat Harries, Toronto General Hospital; Nursing Care Planning — Cathy Cameron, Seneca College; The Discipline Hearing — Helen Evans, North York General Hospital; Dealing with Stress — Elaine Wood and Pat Hall, Seneca College; The Professional and Unionism — Adeline Jack, RNAO; Kidney Transplant — Kathy Janzen, Seneca College.

Did you know ...

Living with End-Stage Renal Disease, a new, 45-page booklet, provides technical information about dialysis and kidney transplant surgery in layman's language. Single copies available without charge from Technical Services of the Bureau of Quality Assurance, 5600 Fishers Lane, Rockville, Md., 20852. Multiple copies at $1.10 purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

News

CUNSA delegates meet in Calgary to examine nursing and the law

Debi Parish

More than 240 student nurses representing 20 university schools of nursing from across Canada attended the annual CUNSA conference held this year at the University of Calgary, in Calgary, Alberta from February 3-6.

The Canadian University Nursing Students Association (CUNSA) is a national organization for Canadian nursing students in baccalaureate programs. Their annual conference is aimed at promoting student interest in nursing activities, and gives members an opportunity to share their ideas and enthusiasm, and keep up-to-date with the latest advancements in nursing.

This year, the official welcome was extended to all university representatives by Dr. Cochrane, President of the University of Calgary. The theme of the conference, "The Nurse and the Law," introduced by Margaret Schumacher, Dean of the Faculty of Nursing at U. of C., was discussed by a panel composed of: J.P. McLaren, Dean of the Faculty of Law, U.of C.; Myrtle E. Crawford, Assistant Dean of the College of Nursing, University of Saskatchewan; Janet Kerr, Professor of Nursing, U.of C., and co-author of *Contemporary Issues in Canadian Law for Nurses;* and the Honorable Mr. Justice Tevie H. Miller.

A discussion held on Saturday focused on the question of euthanasia and the implications for nursing. An excellent film entitled "Whose Life is it Anyway?" prompted lively discussion and debate among those attending.

Elections for the new members of the national executive took place on Saturday afternoon. The newly elected chairperson is Peggy Wareham, Memorial University, St. John's, Newfoundland, who replaces Ingrid Fell, the outgoing chairperson from McMaster University, Hamilton, Ont. The new national research coordinator is Mary Comer, Mount St. Vincent University, Halifax, N.S. Both Peggy and Mary plan to attend the International Council of Nursing (ICN) conference in Tokyo in May.

Representatives were also elected from the three regions — the West, Ontario/Quebec, and Atlantic regions. Regional chairpersons are: Ellen Thom, University of Calgary, Diane Thompson, University of Toronto and Ann Peters, Dalhousie University in Halifax. Regional research coordinators are: Debbie Gibson, University of Calgary, Jeanette Ross, University of Toronto and Cathy Toner, Dalhousie University.

Although business meetings and discussion of nursing issues was a large part of the three-day conference, there was time too for socializing and a trip to Banff. Next year, the national conference will be held at the University of Western Ontario, in London.

Did you know...

The University of Alberta has individual study program packages entitled **Emergency Care for Nurses in Smaller Hospitals** and **Coronary Care.** The programs take 20 hours to complete and are available for $50/package (materials for four), $2./additional participant. For information contact: Continuing Education, School of Nursing, Clinical Sciences Building, University of Alberta, Edmonton, Alberta, T6G 2G3.

Lifestyle Award Program Announced

Health and Welfare Minister Marc Lalonde recently announced details of a program created to acknowledge the contribution made by Canadians in the promotion of positive health lifestyle in their communities.

In announcing the new program, Lalonde indicated that while the main purpose of the Lifestyle Award is to bring recognition to individuals who have worked for years, often unrecognized, to raise the level of health awareness in their community, it is hoped that it will also serve to reinforce voluntary action among Canadians.

Deserving persons may be nominated by individuals living in their community, by community organizations, national and provincial associations or municipal governments.

Nominees should have actively given of their time and energy on a volunteer basis to the improvement of health habits in the community or had significant involvement in the provision of health-related facilities or services. These projects should have been undertaken for a considerable period of time and had a significant impact on members of the community.

Nomination forms are available by writing to the Secretary, Lifestyle Award Committee, Ottawa, KIA 0K9.

Did you know ...

Bell Canada's announced intention of gradually replacing all telephone receivers with ones that do not create an electromagnetic field was the subject of protest by CNA members at the last annual meeting. Members pointed out that certain types of hearing aids equipped with a telecoil or telephone switch, need an electromagnetic field to function properly.

Now, Bell Canada has decided to maintain the electromagnetic field in telephones in the homes or work locations of hearing-impaired users and in public telephones. Researchers will also look into ways to make hearing aids compatible with all types of telephone receivers.

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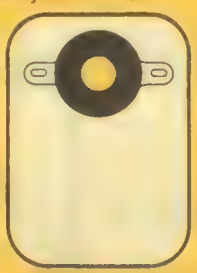






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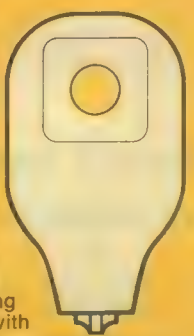
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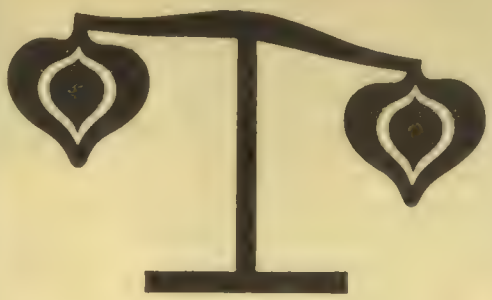
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A Question of Balance



Lynda Ford

The Effects of Chronic Renal Failure and Long-term Dialysis

PART 1

To anyone who knows Stephen, his tears and depression are understandable. For him, chronic renal failure has meant some pretty drastic changes — a change in career goals, loss of financial independence, and emotional instability. After a year and a half on hemodialysis, he feels threatened by constant illness and complications, and by his dependence on a 'machine' to maintain his life.

If you are a nurse working outside a dialysis or transplantation unit, the chances are that the image evoked by the 'chronic renal patient' isn't too favorable. Unfamiliar with the world in which he lives, you may be only too willing to stereotype Stephen as mistrustful, demanding and manipulative, or as apathetic and unresponsive to your efforts. But supporting Stephen depends on the time you take to understand ...



Stephen Davidson was first admitted to hospital in September of 1972, at the age of twenty-two, because of problems with recurrent epistaxis and hypertension. At the time, he was a student in business administration at a local university. Stephen had no past history of renal disease. On admission, he was diagnosed as having hydronephrosis secondary to reflux, and surgery was done to allow direct urine drainage of the kidney pelvices (bilateral nephrostomies).

In 1973, Stephen was admitted to hospital several times for treatment to control his hypertension. By February of 1974, in end-stage renal failure, he began hemodialysis and was considered as a candidate for kidney transplantation.

End-stage renal failure is a condition affecting approximately 1000 Canadians each year. Regardless of its etiology, what the condition means to the patient is that his kidneys can no longer excrete body wastes, that these wastes accumulate in the bloodstream (uremia), that the balance of electrolytes in his body is severely disturbed, and that without treatment, he will die. Medical and nursing management then is directed towards providing for removal of body wastes, artificially maintaining a better balance in body systems, and supporting the patient through the changes that alter his whole way of life.

Stephen began hemodialysis in a state of considerable anxiety. At the age of 23, the irreversible nature of his condition seemed more than he could handle. His uremic state meant that he was fatigued, lethargic, and weak, augmenting his inability to deal with the stress of his illness and its treatment. He was very emotional, crying frequently. He discussed his fears frankly with the nurses and doctors in the renal unit and with his family — there seemed to be so many things to be afraid of. Stephen's family was close to him, and openly supportive, but unfortunately lived in a town 100 miles away from the hospital where he was being treated. Until August of 1973, Stephen was dialyzed through an arteriovenous cannula in his left leg.

Chronic Renal Failure

Chronic renal failure may be the result of one of several disease processes that cause loss of kidney function for variable reasons. Among these causes are:

- Primary Glomerular Disease — glomerulonephritis
- Infection — pyelonephritis, tuberculosis
- Collagen Disease — disseminated lupus erythmatosis, scleroderma
- Obstruction — bilateral renal calculi, prostatic obstruction, neoplasms
- Congenital Disease — polycystic disease, medullary cystic disease
- Hypertensive Nephropathy — malignant and non-malignant hypertension
- Toxic Nephropathy — chronic phenacetin abuse
- Systemic Disease — diabetes mellitus, gouty nephropathy, amyloid disease.

In Stephen's case, reflux of urine into the kidneys caused distention of the kidney pelvices and calyces, resulting in atrophy of the kidney parenchyma, a condition called *hydronephrosis.* Decreased renal function resulted because of increased pressure on the kidney tissue, and hypertension.

Hypertension can lead to kidney disease; conversely kidney disease can cause hypertension ... Fluid retention associated with kidney disease contributes to hypertension. Damaged kidneys also tend to secrete increased amounts of renin, resulting in an augmented aldosterone secretion which causes retention of fluids and electrolytes, and consequently hypertension. Hypertensive nephropathy — further kidney damage because of inadequate blood supply to the kidneys — may result.

Loss of kidney function as a result of any of the causes mentioned may be partial or complete. Stephen suffered complete and irreversible loss of kidney function. More recent ways of dealing with patients in end-stage renal failure include dialysis and transplantation. Stephen was hemodialyzed until a kidney was available for transplantation.

In spite of the relative success of dialysis as a treatment measure for patients in end-stage renal failure, it must be remembered that until successful transplantation, uremia continues to effect not only an imbalance in fluids and electrolytes and the excretion of body wastes, but that it causes changes in the organ systems as well, altering almost every aspect of normal body function.



It is easy to see that the negative effects of uremia on body balance are comprehensive, that the stresses imposed by the condition are beyond anyone's capacity to accept without the greatest difficulty. First of all, he must deal with the fact that he exists with a condition that is life-threatening, and that choices for treatment are not without their own drawbacks and complications.

Physically, the patient feels fatigue, and apathy; generally he feels ill. The feeling of illness often continues throughout dialysis. Often, he must change his lifestyle, his job, his goals. There may be financial problems as a result of his chronic ill-health and the necessity for dialysis. His whole 'self-image' is threatened.

The patient's reliance on dialysis to maintain his life may lead to many conflicts — he may feel discouraged by his dependence, confused by the fact that he is encouraged to maintain independence. His confusion may express itself in many ways: overdependence on medical staff and complete assumption of the sick role, and overt rebellion against the necessary restrictions inherent in his treatment regime are two extreme behaviors that can indicate this confusion.

When Stephen began dialysis, he was still attempting to keep up his university courses, although it presented many difficulties for him. His anxiety was continually expressed through emotional outbursts. It wasn't long before he began to develop cannula infections and other problems associated with dialysis.

By June of 1974, he had given up his courses at the university and had begun training as a hair stylist. This course allowed him to put in as many hours as he felt up to. He was on Social Allowance with a supplement from Manpower to help him out financially.

It was at this time that Stephen began to express that he desperately wanted "freedom" from his dependence on the machine, a kidney transplant, and the chance for a normal lifestyle that it offered. He also began training on the home dialysis program in the hospital in June. After six weeks on the home dialysis program, he was at least able to dialyze himself at home.

THE EFFECTS OF UREMIA

Imbalance in Body Chemistry

Blood tests of the patient will indicate a rise in the products of protein metabolism: *blood urea nitrogen (BUN), creatinine* and *uric acid.* The patient's BUN fluctuates, influenced by a number of factors: renal function, dietary intake of protein, rate of protein catabolism, rate of urea synthesis, and the patient's state of hydration. Serum creatinine, the end product of creatine, an amino acid present in body tissues (especially muscle) is a more reliable indicator of renal function, as it is less variable.

Hyperkalemia, an increase in serum potassium, is chiefly due to the disability of the kidneys to excrete potassium. Serum potassium can rise to dangerous levels in the uremic patient. Serum potassium levels may also be abnormally low in uremic patients as a result of gastrointestinal losses (vomiting, diarrhea).

Serum sodium levels may also be disrupted in uremic states. The kidneys cannot excrete sodium, and a patient's failure to adhere to dietary restriction of sodium may result in increased serum sodium *(hypernatremia)* and water retention. Low sodium values *(hyponatremia)* occur through gastrointestinal losses and increased perspiration.

Serum calcium levels are low in uremia because of a decreased absorption of calcium from the gut, and in association with an elevation in serum phosphate levels.

Calcium/phosphate imbalance disturbs the function of the parathyroid gland. Because of a decrease in serum calcium, the parathyroid secretes additional parathyroid hormone in an attempt to restore serum calcium levels to normal. Secretion of further parathyroid hormone as a result of hyperplasia of the parathyroid gland may eventually cause elevated serum calcium levels by stimulating reabsorption of calcium from the bones. *Bone disease,* a common problem in uremic patients, is related to the imbalance in serum calcium, serum phosphate and parathyroid gland function.

Serum magnesium rises in uremic patients due to the inability of the kidneys to excrete magnesium. Low serum magnesium levels are the result of losses through vomiting and diarrhea.

Metabolic acidosis occurs in the patient with uremia because his kidneys cannot excrete acid as ammonium.

Because of the disability of the kidneys to dilute urine, the patient's water load cannot be excreted rapidly or adequately resulting in *fluid overload.*

Imbalance in the Respiratory System

Uremic patients have an increased susceptibity to infection, and a prime site for infection is in the lungs. *Pulmonary edema* may result from fluid overload and congestive heart failure. *Intrapulmonary bleeding* is possible as a result of the impaired platelet function associated with uremia. The patient's respiratory rate may increase to compensate for his acidotic state.

Imbalance in the Cardiovascular System

Hypertension occurs in a large percentage of patients with irreversible renal failure. As a consequence of kidney damage, the kidney secretes increasing amounts of renin, resulting in rising aldosterone secretion and thus retention of fluid and electrolytes. Hypertension is the result of this process, and in turn it may cause cerebral vascular disease, coronary heart disease, and congestive heart failure.

Congestive heart failure is often associated with hypertension and fluid retention in the uremic patient, and it may result in pulmonary and generalized edema.

Pericarditis also occurs with uremia, although the causes are unclear. Cardiac tamponade may follow.

Cardiac arrythmias are often related to elevated serum potassium and serum magnesium levels. Elevated serum magnesium and potassium levels may result in cardiac arrest.

Imbalance in the Hematological System

Most patients with chronic renal failure are *anemic.* Normal hemoglobin readings may ride between 6-8 gm/ 100 ml. The normal kidney secretes erythropoietin, a substance that stimulates the bone marrow to produce red blood cells. Patients in chronic renal failure secrete inadequate erythropoietin, and the result is a decrease in red blood cell production. Red blood cells tend to show a shortened life span in patients with elevated BUN levels.

Uremic patients also have a tendency to bleed, probably related to a deficiency in the number and quality of platelets.

Skin Changes

Changes in the skin are uncomfortable for the patient in uremia.

Pruritis is severe. The skin is generally dry and scaly due to calcium/phosphate imbalance. If the patient scratches itchy skin, the scratches do not usually heal well, and the possibility of infection is great.

Skin color changes, becoming sallow yellow-brown to gray in pigmentation. Anemia gives rise to pallor.

Clotting abnormalities make *bruising* and *petichiae* common. Perspiration generally decreases. Nails become brittle and thin, hair is dry and may fall out.

Imbalance in the Gastrointestinal System

Gastrointestinal bleeding can occur anywhere along the GI tract in patients with uremia, perhaps due to defective clotting mechanisms (platelet deficiency). *Anorexia, nausea and vomiting* are common in uremic patients, and contribute to weight loss, and further electrolyte imbalance. Decreased salivary flow, dehydration, and mouth breathing (acidosis) may result in *parotitis* or *stomatitis.* The patient may also complain of a metallic taste in his mouth, loss of smell, and thirst.

Imbalance in the Neurological System

The nervous system of the patient in uremia is affected in a comprehensive way.

Mental function can be sluggish, marked by apathy and an inability to concentrate, limitations in attention span, and confusion. Coma and convulsions may occur.

Personality and behavior changes in the patient with renal failure are remarkable. These include increased irritability, emotional lability, depression and withdrawal, agitation, demanding behavior, and complete lack of cooperation. Psychosis with hallucinations may develop.

Peripheral neuropathy may reveal itself in numbness or burning of extremities and slowed reflexes. *Muscle changes* may include twitching, tremulousness, nocturnal cramps, and atrophy.

Skeletal System and Bone Disease

Because of changes in the calcium, phosphate and parathyroid balance, bone disease is a problem for uremic patients.

Bone pain, joint calcifications and fractures occur. Repair mechanisms in bone disease cause an increase in serum alkaline phosphatase levels. If serum calcium and phosphate levels are high, soft tissue calcifications may occur.

Reproductive Changes

Chronic renal failure means reproductive changes in both men and women. *Male fertility decreases* with a rise in serum creatinine. *Impotence* is a major problem. *Amenorrhea* occurs in women. Both men and women indicate a decrease in libido.

Chronic renal failure patients also have an increased susceptibility to *infection.* Now that dialysis treats kidney failure itself, infection is the major cause of death in uremic patients. A change in antibiotic metabolism makes infection difficult to treat. Uremia is also associated with *slow wound healing.*



Treatment of Chronic Renal Failure

With improvements in the techniques of dialysis, patients can now be dialyzed more effectively. In addition to dialysis, the uremic patient must adhere closely to restrictions in fluid intake and diet, and to a medication regime.

Diet

In the past, dietary restrictions have been severe. Now, in most cases, restrictions are moderate, the patient's ability to live with his diet being considered as a major factor in its success. But the diet cannot be abused without consequence, and in this way is similar to prescription medications for the patient in chronic renal failure.

Generally, patients on hemodialysis are allowed a weight gain of 1.5 kg between dialysis treatments. Daily fluid intake often consists of 500 cc plus the previous day's urine output. The use of alcohol is restricted because of its adverse effects on blood pressure, and because it usually means an increase in fluid intake. Obese patients are calorie restricted.

Sodium, potassium and fluids are restricted and monitored, the patient's weight, blood pressure, BUN and creatinine levels being the indicators for restrictions. Protein is also restricted because the products of protein metabolism are not excreted normally. The importance of intake of high quality protein, with essential amino acids for body building (found in eggs, milk and meat) is emphasized in dietary teaching.

Medications

Medications for the patient on dialysis for chronic renal failure attempt to make up for body balance interrupted by uremia. They may include:

- **phosphate binding agents** — aluminum hydroxide products, such as amphogel, keep phosphate from being absorbed into the bloodstream, and help to deter a further rise in serum phosphate levels. None of the prescribed medications contain magnesium, and the patient must realize that he cannot substitute magnesium products as his kidneys cannot excrete magnesium.
- **vitamins** — multivites and folic acid are necessary to supplement the dietary source of vitamins, because dietary restrictions are comprehensive, and because water-soluble vitamins are dialyzed out. Vitamin D is often prescribed as it helps to absorb calcium from the digestive tract, and thus to prevent bone disease.
- **anticoagulants** — such as coumadin may be prescribed to decrease platelet adherence or clotting, thus maintaining patency of an arteriovenous shunt.
- **iron** — ferrous gluconate may be given intravenously to build serum iron, and counteract anemia.
- **PRN medications** — antihypertensives may be necessary where hypertension is a problem.

— laxatives may be necessary because of the constipating effect of aluminum hydroxide. Only prescribed laxatives are to be used by the patient, and magnesia is not to be taken.
— valium may be necessary for anxiety
— antibiotics may be needed periodically for treatment of infections. The use of many antibiotics is restricted because of altered antibiotic metabolism.

When he began dialysis, Stephen was on a 2 gm Na, 60 mEq K, 60 gm protein diet. Because his daily urine output was 1500 cc, he was allowed 2000 cc fluid in 24 hours. His medications included folic acid 5 mg q.i.d., cloxacillin 500 mg q.6.h. (for a cannula infection), and valium prn for anxiety. He was also on phosphate low cookies (containing aluminum hydroxide) t.i.d. with meals.

What happens in dialysis

The healthy kidney eliminates waste products and maintains fluid and electrolyte balance in the body through filtration in the glomeruli and reabsorption and secretion in the tubules. Filtration, osmosis and diffusion are involved. When these functions are disturbed, dialysis is the means of elimination of wastes and maintenance of electrolyte balance.

In *peritoneal dialysis,* the peritoneal membrane is used as a dialyzing membrane to remove nitrogenous wastes and to restore to normal body fluids and electrolytes. Osmosis, diffusion and filtration occur across this membrane, between the fluid introduced into the peritoneal cavity (dialysate) and the blood supply of the abdominal organs. Patients on long-term peritoneal dialysis (or home peritoneal dialysis) have indwelling silastic catheters inserted in the peritoneal cavity and these can be expected to last for years. Dialysate is introduced into the peritoneal cavity via the catheter, stays there for a short period of time, is then drained out, and a new cycle is begun. Automatic peritoneal dialysis machines allow the patient to sleep while dialysis is taking place.

One of the drawbacks to peritoneal dialysis is the time involved in the procedure. Generally patients using this method must be on dialysis for 40 hours per week. Problems with infection (peritonitis) used to be a considerable drawback to peritoneal dialysis, but now infections are much fewer in number.

Peritoneal dialysis causes protein depletion, which can be alleviated by increasing dietary protein. The procedure cannot be used if the patient has abdominal adhesions.

Some advantages to peritoneal dialysis: it is simpler, and easier for the patient to initiate and terminate than hemodialysis. Many patients are now involved in home peritoneal dialysis programs, which normally involve a two to three-week training period before the patient is ready to dialyze himself at home.

Hemodialysis involves circulation of the patient's blood from an artery through a dialysis machine, and back into the patient via a vein. The artificial kidney eliminates waste products from the blood by filtration and diffusion across a semipermeable membrane

1. "Weighing in" on admission to the dialysis unit.

2. Admission to the dialysis unit includes taking the patient's blood pressure and temperature.

3. Teaching the patient to prepare the dialyser for dialysis.

4. Drawing up heparin to prime needles.

5. Patient learning to do her own venipunctures for initiation of dialysis.

6. Beginning dialysis.



Photos courtesy of University of Alberta Hospital

The patient's blood flows within a semipermeable membrane and the dialyzing fluid flows on the outside of the membrane, drawing out wastes from the blood. Hemodialysis is done three times a week for a period of three to seven hours each time depending on the patient's body size and adherence to diet and fluid restriction. In many centers, patients are involved in home hemodialysis programs in order to learn to dialyze themselves in their own homes.

Repeated hemodialysis necessitates easy access to the patient's bloodstream through a shunt. Several types of access are used, the main types being silastic cannulas and subcutaneous arteriovenous fistulas. Both of these methods allow shunting of blood from an artery to a nearby vein. With a cannula the patient's arterial blood flows through silastic tubing into a vein, whereas a fistula involves surgical anastomosis of an artery and a vein. Grafts are used when the patient's vessels don't provide adequate access.

When the patient has a cannula, the connection in the shunt is opened for dialysis and the arterial tubing is attached to the tubing leading to the dialyser. The venous tubing is attached to the tubing leading out of the dialyser. Shunt failure may arise due to clotting or infection. If these cannot be remedied, a new site must be chosen for the shunt.

The cannula offers painless, easy access to the patient's bloodstream. However, it requires some care. The cannula is external, and accidental separations can occur. Dressings must be done to guard against infection.

The AV fistula allows for greater freedom of activity for the patient. Infections are reduced because there is no external connection, and accidental bleeding is not a problem. Regular venipunctures for the initiation of dialysis, however, can be difficult for the patient.

■ Why transplantation

Improvement in the techniques of dialysis and the possibility of home dialysis have allowed patients in end-stage renal failure to keep up jobs and have reduced the necessity for in-hospital treatment. Patients can now be dialyzed successfully for a longer period of time ... But the problems associated with uremia and dialysis itself are such that transplantation is still the objective of patients involved in long-term dialysis programs. Some of the problems associated with dialysis are:

- ***dialysis disequilibrium syndrome*** — This is thought to occur because removal of urea nitrogen from the blood occurs at a rate relatively rapid to its removal from the brain. Reverse osmotic gradient pulls fluid into the brain resulting in cerebral edema. Symptoms: headache, nausea and vomiting, confusion, possible hallucinations and convulsions.
- ***acute hypertension*** — This is thought to be caused by anxiety related to dialysis, and the disequilibrium syndrome.
- ***hypotension*** — Thought to be caused by

rapid removal of fluid during dialysis

- ***nausea and vomiting*** — Causes include disequilibrium syndrome, hypertension, hypotension, anxiety, possible peptic ulcer, inadequate dialysis with retention of uremic toxins
- ***headache*** — Due to anxiety, hypertension, and the disequilibrium syndrome
- ***bleeding*** — Due to heparinization during dialysis
- ***fever*** — Usually a result of infection
- ***muscle cramps*** — Thought to be due to rapid sodium and water removal
- ***arrythmias*** —Due to hypotension, electrolyte disturbance
- ***chest pain*** — Hypotension and arrythmias may lead to angina
- ***restlessness*** — Due to anxiety, disequilibrium syndrome
- ***depression and hostility*** — Related to the necessity for the regular stress of dialysis
- ***shunt problems*** — In hemodialyzed patients, shunt problems are common, and may include clotting and infection. Loss of shunt sites through infection can threaten the continuity of therapy for hemodialyzed patients.

■ Awaiting Transplantation

Stephen's eagerness for a transplant was not a wild hope for a cure that would end all his problems. The difficulties he had because of uremia and dialysis, and the restrictions necessarily imposed on his lifestyle naturally inspired his interest in any alternatives. But as with most patients on a dialysis/transplant program, he had been fully aware of transplantation as a realistic alternative since the beginning of his treatment. The nurses who saw him weekly, a nurse-teacher on the dialysis program, a home dialysis instructor, medical staff, and social workers had begun to teach him at an early date about the possibility of a kidney transplant to replace his current treatment.

By August of 1974, Stephen was admitted for the creation of an arteriovenous fistula in his left arm, because he had had so many problems with cannula infections in the left leg site. At this time his blood results indicated: Hgb 8.1 gm; phosphate 5.2 mg%, calcium 9.1 mg %, creatinine 9.6 mg %, BUN 57 mg %.

By October, another left leg shunt infection had to be treated with antibiotics, but the treatment was unsuccessful. As the fistula in his left arm was small and tortuous, another shunt was inserted in his right leg. After this procedure, he returned home and continued dialysis there. Psychotherapy had since been initiated for sexual problems. Further shunt problems led to Stephen's readmission in June of 1975, and he was dialyzed in-hospital using the left arm fistula. By this time, Stephen was very anxious, discouraged, and depressed. Venipunctures for dialysis were difficult because the fistula vessels remained tortuous. Stephen cried every time the needles were inserted and was increasingly apprehensive with each dialysis run. His anxiety over his illness seemed to find a focus on the needles he received each time. Emotionally, he tolerated dialysis very poorly.

In the meantime, Stephen's family had been tissue-typed for possible kidney donation. His brothers and sisters were all willing to donate a kidney, but several were younger than Stephen, and therefore unsuitable as donors.

An older sister, married with two children, was a fair match with Stephen, and she was very willing to donate a kidney. It was decided after further tests, that Stephen would receive a kidney transplant in July, with his older sister as donor.

After almost a year and a half on dialysis, Stephen was excited about the transplant and looking forward to the independence that it offered. He began to say goodbye to the renal nurses who had cared for him during that time.

■ Implications for Nurses

The nurse's role as teacher and supporter is an important key in helping the patient in chronic renal failure adapt to his illness and its treatment, and to the disappointments that he may have to face... Nurses who work with patients in renal failure on a daily basis are well aware of the stresses on the patient as an individual; the stress of chronic illness, the threat and actualization of complications, and the problems posed by medical treatment. More important perhaps, they get to know the patient himself; in helping him learn to cope with his condition, they become involved in a relationship with the patient and his family, and see him as a person of many dimensions in the context of his life.

Take Stephen as an example. To the nurse in the renal unit, his tears and depression can be seen as his response to his whole life situation, not as a childish reaction to needles. His illness has brought about a change in his choice of careers, in his financial status, in his family relationships. From independence and health he has become dependent and feels constantly ill; he is sexually impotent; and he is frightened. The renal nurse knows Stephen, knows that his goals, his lifestyle, his "self", have undergone a stressful change, and she is able to respond to him in a helpful, supportive way. Guided by Stephen's acceptance of treatment and his level of knowledge, she is able to teach him about his illness and understand his receptiveness or lack of it. She shares his hope for a successful transplant and helps him to prepare himself for transplantation.

Not so the nurse on another floor of the hospital. If Stephen is admitted to her ward, and there is a good chance that he may be, she is confronted by a "renal patient," lethargic, sometimes demanding, and "childish." She may be unfamiliar with what end-stage renal failure means, and with his treatment regime. If she is out of touch with what all this means to Stephen, she may interpret his behavior as plain difficult and respond with feelings of inadequacy and resentment. It becomes easy then to stereotype Stephen as "just another renal patient."

Understanding the dynamics of chronic renal failure, and understanding Stephen, may take time. But supporting Stephen depends on the time you take to understand.

Acknowledgment: *The author would like to thank the staff at the University of Alberta Hospital in Edmonton for their co-operation and assistance in the research and writing involved in preparation of this article. Their help during my visit, particularly the help of Anita Yanitski, clinical instructor in the Renal Unit, is greatly appreciated.* — L.F.

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Clinical Wordsearch no. 4

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has five words. (Answers page 30).

G C Y S T I T I S I V L E P M G U R
I L N N T I C A T H E T E R U R E S
M W O S Y Y C N E U Q E R F I D I B
M E R M D I A L Y S I S O N D S D U
U I H K E M U I C L A C E A O P H N
N G P I I R E J E C T A L R S R F S
O H E D E L U B U T T B H E U O L I
S T N N K S A L T R L P D R L T U S
U A T E A C I D O A E A I E U E I O
P I H Y P E R T E N S I O N C I D T
P M U C A M I N O S E E V A L N D P
R E U I I P O R C P N P L L A U I O
E T R R N T D L C L O P H N C R U R
S O E U I Y O E T A T S O R P I R H
S Z T R H S I V P N S I N H I A E P
I A E O E D E M A T T U M O R T S E
V P R D W T C I B U P A R P U S I N
E P A R E N C H Y M A I R U Y P S S

1 A variety of nephritis characterized by inflammation of the capillary loops in the glomeruli of the kidney. *(18)*
2 Distention of renal pelvis and calices with urine. *(14)*
3 Rubber or silastic tubing; may be straight or indwelling. *(8)*
4 Amber colored liquid excreted by 12. *(5)*
5 Function of the kidney. *(8)*
6 Pertaining to 12. *(5)*
7 Often pitting around the ankles. *(6)*
8 The presence of protein in the urine. *(11)*
9 A method sometimes used in patients in kidney failure to remove from the blood elements that are normally excreted in the urine. *(8)*
10 A method of dialysis which is not extracorporeal. *(10)*
11 Basic unit of function of the kidney. *(7)*
12 Sometimes borrowed, hopefully not blue. *(6)*
13 As it descends and ascends it forms a loop. *(6)*
14 Acts as a cistern. *(7)*
15 An advanced form of mathematics, may be renal. *(8)*
16 Gland subject to hypertrophy in older men. *(8)*
17 What short-wave radios and bladder infections have in common. *(9)*
18 Not basic to anything. *(4)*
19 Inflammation of 14. *(8)*
20 Has a burning quality when accompanying 19. *(4)*
21 Not full. *(5)*
22 To avoid infection, urinary catheter drainage systems should be maintained this way. *(6)*
23 You've got it with a diastolic > 100 mm Hg. *(12)*
24 Heavy on a dieter's mind. *(6)*
25 Presence of pus in the urine. *(6)*
26 Presence of nitrogen-containing compounds in the blood. *(8)*
27 Element deleted from or reduced in diets of many with renal disease. *(6)*
28 Useful for those who would rather switch than fight. *(10)*
29 The downward displacement of a kidney. *(12)*
30 Mineral found in milk and sardines. *(7)*
31 The essential or functional elements of an organ. *(10)*
32 What some bodies do to unwanted organs. *(6)*
33 Type of medication given to prevent a 32. *(17)*
34 Situated above the public arch. *(10)*
35 What Lot's wife became. *(4)*
36 Null's partner. *(4)*
37 Basin formed by the hip bones and lower part of the vertebrae. *(6)*
38 A growth. *(5)*
39 What people in glass houses shouldn't throw. *(6)*
40 Type of acid which precipitates to form crystals. *(4)*
41 Carries urine from kidney to bladder. *(6)*
42 Blood Urea Nitrogen. *(3)*
43 The lower it is, the stronger the acid. *(2)*
44 Intravenous Pyelogram. *(3)*
45 Important ingredient in Maalox. *(2)*
46 A drug which may be used in treating T.B. of the kidney. *(3)*
47 Liquid. *(5)*

Principles of Primary Nursing

The Role of the Head Nurse in Primary Nursing

Diane Bartels, Vivian Good, Susan Lampe

Primary nursing as a philosophical and organizational approach to hospital nursing, is a pattern of care developed in the mid-Western United States almost ten years ago. Its chief characteristic is a one-to-one relationship between the patient and the nurse who provides his care. Innovator Marie Manthey has described primary nursing as "essentially a return to the concept of 'my' nurse and 'my' patient."

Supporters of the system point out that it offers a means of providing the personalized, comprehensive or total care that both patients and providers of care often complain is missing in today's health care system. From the point of view of the nurse, the key to primary nursing is her accountability for the total care of all patients assigned to her, on a day-to-day basis, from admission to discharge. Each nurse is a "primary nurse" when she is responsible for the care of a patient throughout his stay in hospital; she is an "associate nurse" whenever she cares for a patient whose nurse is off-duty.

Primary nursing was first introduced in 1968 on a trial basis on a 24-bed medical unit at the 829-bed University of Minnesota Hospitals in Minneapolis, Minn. Since then, hospitals in many states of the U.S., including California, Michigan, Wisconsin, Illinois, Pennsylvania, North and South Dakota, Iowa, and Washington, have introduced primary care programs. Last year, the *American Journal of Nursing* (May, 1976), while conceding that primary nursing is "still in the experimental stage" described the system as "highly rewarding for both patients and nurses" and predicted that it was on its way to becoming widely accepted on a national basis.

In Canada, application of the principles of primary nursing has been confined largely to the one-to-one relationship of public/community health nurses with individual patients in their homes and to psychiatric and intensive care settings in some hospitals.

Recently, however, nurses working in other areas of general hospitals have indicated a growing interest in learning more about the primary nursing concept and how it can affect their relationship with their patients, with other health professionals and with their fellow nurses.

1. 24-hour decision-making for several patients by one nurse;
2. nursing assignments based on matching patient needs and nursing skills;
3. nursing care planner is the care-giver;
4. direct care-giver to care-giver communication;
5. head nurse in a crucial role as leader, clinician, consultant, evaluator, staff developer and teacher.

Primary nursing brings about changing roles, responsibilities, and communication patterns for all members of the health care team. The head nurse, as she introduces new staff to primary nursing and its day-to-day applications, is in an ideal position to generate enthusiasm for the goals of the concept. In attempting to implement this new care pattern, she must continually promote the philosophy behind it by her support and recognition of its principles. In the long run, it is the positive attitude and high motivation of the head nurse that will determine the success or failure of the program wherever it is introduced.

One nurse, one patient — planning care together ... Primary Nursing, as a philosophical and organizational approach to hospital nursing, has been defined by Manthey[1] as encompassing five principles:

- 24-hour decision-making for several patients by one nurse;
- nursing assignments based on matching patient needs and nursing skills;
- nursing care planner is the care-giver;
- direct care-giver to care-giver communication;
- head nurse in a crucial role as leader, clinician, consultant, evaluator, staff developer and teacher.

Of these, it is the last principle, the role of a head nurse in primary nursing, that the authors examine in the light of their own experience. Their observations reflect traditional aspects of this position, as well as some aspects that are unique in a primary nursing setting.

If the head nurse is to successfully assume the role of leader, clinician, consultant, evaluator, staff developer and teacher, two conditions must be met within the organizational set-up. First the nursing station should be of a reasonable size with the capacity to handle 25-35 patients. Second, a strong managerial role for the station secretary (or ward clerk) should be developed.

Why are these factors vital? Size of station takes on considerable importance when the reorganization of station functions is realized. With dissolution of the team leader position, the head nurse becomes the sole quality control agent of that station. A small station, with fewer patients and personnel to coordinate, affords the head nurse more time for emphasis in the clinical area.

This clinical emphasis is strengthened further by the second prerequisite, a strong managerial role for the station secretary. The head nurse will never be in a position to focus on patient care if she is absorbed in activities centered at the main desk. This implies that the head nurse must want to relinquish many of the managerial functions and that she must have someone who can responsibly assume these for her. In most cases, the activities of station secretaries can be extended to include areas of communication, ordering of forms and supplies, scheduling procedures, traffic direction, staffing hours, order transcription, and possibly reception of verbal and telephone orders.

When these criteria are met, at least the supportive environment for a clinically oriented head nurse role is established.

The head nurse as leader

In any nursing organization the head nurse role, broadly defined, is that of leadership. The main focus of that leadership in primary nursing is quality patient care. To accomplish that goal, the head nurse's emphasis must be more clinically-oriented and less managerial than traditionally demonstrated in other systems.

If the goal is quality patient care, then the head nurse must be out in the area where this care is given. Both as a role model and by working closely with the staff and patients, she can more effectively determine the standards under which patient care will be delivered. Her own practice, expectations, and priorities have an important influence on staff performance. Patient care must be constantly held as first priority and staff energies directed towards use of the nursing process in pertinent observations, assessment of patient needs, care planning, intervention, and evaluation. It is our experience that individuals will most often excel in those areas consistent with the indicated expectations and rewards.

In addition to the setting of standards, another important aspect of the head nurse leadership role is her style of leadership. In primary nursing, her leadership style must facilitate independent and interdependent decision-making. This is achieved through the process of decentralization whereby the head nurse delegates authority, responsibility, and accountability for the nursing care of a given number of patients to the primary nurse. The extent of this delegation increases as the proven ability of the individual nurse to assume responsibility broadens. Theoretically, each Registered Nurse and many Licensed Practical Nurses (or Registered Nursing Assistants) can be developed to the point of effectively managing the high degree of responsibility required in primary nursing.

To foster decision-making and accountability, the head nurse must be able to relinquish tight controls. The pendulum between autocratic and democratic leadership must swing more in favor of the latter. Basic to this democratic style is the ability of the head nurse to assume risks. Risk-taking is of vital importance if primary nurses are to know the freedom of testing the "rightness or wrongness" of their own decisions. Staff must know that in some circumstances being wrong may be acceptable. It may not be ideal but it is human and sometimes the best a person could do in a given situation.

As staff competence in decision-making develops, the head nurse's leadership emphasis shifts naturally from staff development to staff consultation. The strength of her consultation role is proportional to her excellence in clinical knowledge and nursing practice. Thus, her leadership power base evolves from personal expertise rather than merely ascribed power associated with the position.

A vital adjunct to the role of consultant, is the ability of the head nurse to trust and be trusted. The staff must not only feel that the head nurse is competent but approachable, open and equitable. When the head nurse and staff can work together in an atmosphere of open communication and mutual respect, the potential for excellent patient care and professional development is unlimited.

Finally, the head nurse must demonstrate leadership in understanding of and commitment to the concept of primary nursing. She is responsible for assisting staff in the implementation process and she is vital to the maintenance of the principles. The transition process from team systems or task orientation is long and difficult. An adjustment period of twelve to eighteen months should be anticipated.

The head nurse as evaluator

In her role as evaluator, the head nurse must deal with assessment of patient needs and assessment of a particular nurse's ability to meet those needs. Ideally, she will match the two appropriately.

In evaluating a patient's needs or identifying his problems, the head nurse considers the presenting complaint, as well as co-existing conditions. Data is also extracted as available and appropriate from the following:

- past records
- the nursing admission history
- the physician's history and physical exam
- referral notes
- personal encounter with the patient or family.

From this information, she attempts to predict the course of hospitalization, focusing on long-range plans rather than one day's

The Role of the Head Nurse

expectations. Her initial assessment is not infallible and may require readjusting at a later date.

Evaluation of the nursing staff is an ongoing process. The organizational pattern of primary nursing provides many tools to facilitate staff evaluation. A single staff nurse is responsible and accountable for total ongoing care of specified patients. Therefore, the nursing admission history, daily progress notes, written care plan and observation of that plan executed provide pertinent information about the primary nurse. They reflect her interviewing skills, knowledge and understanding of her patient's problems, her ability to monitor those problems, to provide relevant care, and to evaluate her own effectiveness.

Since the head nurse is physically present in the patient care area instead of at the desk, she is able to observe the quality of nursing care being given. She may also give bedside care to a patient whose primary nurse is off duty. This provides an ideal opportunity to evaluate the patient's condition and the completeness or effectiveness of the nursing care plan recorded in the patient record and/or Kardex.

Many aspects, then, of the primary nurse's performance are readily assessed with concrete examples taken from her clinical practice. These examples become valuable tools in preparing meaningful written evaluations for periodic progress discussion.

The evaluation of patient needs and of nurse performance are then appropriately combined in the formulation of the nurse-patient assignment by the head nurse. She assigns each patient to a nurse within 24 to 48 hours of the patient's admission. This is a complex decision. As previously stated, the head nurse uses all available data to evaluate the patient's psycho-social and physical needs. In addition, she must consider the acuity level of the patient, his education needs and any personal preferences. This data is then considered in reviewing the staff nurses who might be available for assignment. In selecting the best nurse, the foremost considerations are the interpersonal and technical skills of the individual and the scope of practice permitted by licensure laws as compared with what is needed by the patient. Other factors include the current case load of the nurse and any special interests the nurse may have. Are there nurses, for example, who particularly enjoy working with surgical versus medical patients, with newly diagnosed diabetic patients, or with geriatric patients?

Another influence is the nurse's work schedule. Usually a nurse is not assigned new patients during the week prior to beginning the night shift. At times a nurse may ask to care for a particular patient. This can be appropriate provided the head nurse agrees that the nurse's selection is compatible with her abilities and the needs of the patient. Also, a primary nurse is encouraged to re-establish her relationship with a patient to whom she was assigned during a previous hospitalization.

Educational needs of a nurse might be yet another consideration influencing assignment. However, in this case the head nurse is responsible for helping the nurse to learn and practice the necessary skills.

Lastly, geographical location of each patient on the station plays a part but should not be a major criterion. If geography is permitted to strongly influence assignment, it defeats the principle of nursing assignments based on skills needed by the patients.

Teacher, staff developer, and facilitator

Using the evaluation process described, the head nurse is not only able to assess which nurse is most appropriate for a particular patient but she is also able to determine educational needs of the nursing staff of the unit.

Areas most frequently identified include the following:

- interviewing and assessment skills
- technical skills especially with the new graduate
- disease and its implications for patient care
- complex psycho-social problems
- teaching techniques
- care planning
- communication skills in reference to interaction with other health disciplines or agencies
- change process
- problem-solving and decision-making.

Without doubt the need for skill in interviewing and data collection influences the entire nursing process. Poor interviewing techniques and insufficient data collection can only result in deficient planning. Primary nurses frequently express difficulty in knowing what kinds of questions to ask of patients or how to approach "sensitive" topics. The head nurse is responsible for finding an effective method to develop these skills.

The head nurse can also be instrumental in developing technical skills of the new graduate. One way of doing this is to assign the nurse to patients who have needs in the area in which the nurse requires practice. The head nurse is then obviously required to provide the necessary teaching, support, and supervision during this procedure.

The desire for greater understanding of disease and disease process rates high priority with primary nurses in terms of educational needs. Perhaps this is a reflection of the "wellness" orientation currently being stressed in some nursing schools in the U.S., almost to the exclusion of disease process. Unfortunately, in a hospital setting, nurses are caring primarily for persons whose "wellness" has been interrupted by disease. If they are not fully equipped to handle this crisis, their care can only be deficient. Many primary nurses have recognized this and are now requesting classes devoted to disease process.

The close relationships that often exist between primary nurse and patient, make the handling of death particularly stressful. Dealing with death and dying or with the patient who has severe emotional problems sometimes necessitates other resources. Patient care conferences attended by representatives of all health disciplines or by special resource persons can be beneficial. Discussion of readings and/or experiences may also help considerably. Severe problems may require consultation.

Three important points should not be overlooked in reference to patient conferences:

1. The head nurse should encourage primary nurses to organize a conference as a means to inform other staff of patient needs or to elicit assistance with creative ideas in approaching the care of a particular individual. Directing a conference develops the primary nurse's ability with group process and expands her own horizons through various viewpoints presented. Conferences also help the primary nurse deal with the large responsibility for patient care and prevent feelings of being "an island unto one's self."
2. The head nurse should encourage the inclusion of patient and/or family in conferences as appropriate. This can assist in clarifying and solidifying the nurse-patient contract.
3. The head nurse should not fail to encouarge utilization of staff talents inherent in the nursing group on the station. This recognizes, reinforces, and rewards individual abilities. In turn this promotes job satisfaction, high morale, and group sharing.

Since patient and family teaching is one of the primary roles of the nurse, attention to this area is essential. Didactic classes on the principles of education, experimental situations with teaching, and evaluation of the effectiveness of teaching skills will help improve this area. Nurses can also learn useful teaching skills through teaching new technical skills or information to their peers. Continuous support by the head nurse will

encourage growing proficiency in patient teaching.

Care planning requires some assistance. Initially, primary nurses may be hesitant to commit themselves in writing. They need guidelines and positive reinforcement from the head nurse. Review of written care plans by the head nurse is essential to indicate to the staff this expectation of performance.

If inappropriate deviations from the care plan or lack of adherence to the primary nurse's care plan by other nurses occur, it may be necessary for the head nurse to intervene. Reiteration of the importance of following a care plan reinforces the fact that nursing directives are as important as physician orders to planned care and continuity. Sometimes, too, the primary nurse needs a reminder to include the patient in discussion about his plan of care during his hospitalization.

Communication channels in primary nursing are radically different from traditional hospital systems: the head nurse is no longer the single information source and primary decision-maker on the station. Instead, she promotes direct *care-giver* to *care-giver* communication by supporting the primary nurse as the nursing person responsible for communication of verbal and/or written data concerning her patients to physicians and any other health disciplines involved in the care of her patients. In addition, change of shift reports are organized so that the nurse who has been responsible for patient care reports directly to the nurse who will assume these responsibilities on the next shift.

If the transition from a traditional system of station organization to primary nursing is to succeed, it is essential that the head nurse adequately prepare personnel for the change. Her approach to this task depends upon her own approach to change. Again, her openness, willingness to experiment, and sense of adventure will have a direct influence on the staff. As in any other aspect of station activities, change necessitates a positive support system if it is to succeed. Some notable factors the head nurse should consider in promoting changes are: sensitivity to where the staff is mentally and emotionally in terms of change; group involvement in decision-making about the innovation with recognition of contributions made by staff members; good sense of timing in terms of proceeding with the change process; close communications so that a clear understanding of the change is commonly held; close follow-up so that feelings and problems are dealt with before they become disproportionate; finally, much positive reinforcement and feedback.

The primary nurse must be competent in the areas of problem-solving and decision-making. The head nurse facilitates these skills as a consultant and validator by acting in a way which will maintain open communication, support and teach the decision-making process to less proficient staff, recognize and encourage staff who make good decisions, and disseminate the clinical knowledge which the staff nurse requires to make her decisions.

When the head nurse recognizes that good judgment is being utilized, immediate recognition of that fact provides feedback and reinforcement essential to staff satisfaction and performance. As more experience is gained and self confidence grows, the need for frequent validation will lessen. The staff nurse will gain more confidence in her own abilities and the head nurse will learn to trust the individual's judgments. Responsibility allowed will then be appropriately proportional to proven ability. At this point interactions between staff nurse and head nurse become informative sessions. The staff nurse will describe proposed plans or actions already executed and their outcomes rather than asking permission to act. In this context the head nurse maintains final responsibility for the station activities while fulfilling her role as quality control agent.



Photo courtesy of Health Sciences Resource Centre, Winnipeg

Rewards

In primary nursing, the rewards for the head nurse come from her clinical orientation:

- Because she is relieved of many administrative tasks she has the opportunity to again become a bedside nurse herself. She is able to become involved with the patients as people and not just statistics through bedside rounds with the primary nurse, through patient interviews, and through direct teaching and participation in bedside care.
- The greatest reward of primary nursing is improved morale and personal growth among nurses who work in an atmosphere which promotes expression of the full breadth and depth of their professional skills. Each staff nurse can see directly the result of her individual efforts. This direct feedback fosters enthusiasm and concern to increase technical skills and clinical knowledge. Individual nurses are recognized for an area of expertise and invited to teach the other staff. More creative problem-solving is encouraged when one nurse is responsible for the comprehensive care of specified patients.
- Continuity of patient assignments contributes to increased personal commitment. The patient can identify "my nurse" and the nurse can identify "my patient." The primary nurse assignments concern

people and not tasks. Family members are especially appreciative to have one particular nurse to consult.

- Physicians' comments are uniformly favorable when they discover that the responsibility for the care of their patient is assumed by one individual who is thoroughly familiar with the medical problems involved and is qualified for and committed to providing optimum nursing care.

The head nurse who watches her staff develop professional skill and competence has the right to be proud. Primary nursing provides the organizational system which makes quality, patient-centered care a possibility. Head nurse leadership makes it a reality.



Vivian Good



Diane Bartels



Susan Lampe

Vivian Good, Diane Bartels *and* **Susan Lampe** *have each held head nurse positions on Primary Nursing Units. Diane Bartels was the first head nurse on the pilot station at University Hospitals, Minneapolis, Minnesota where Primary Nursing originated. She was succeeded by Vivian Good. Both worked with innovator Marie Manthey in the development of this new approach to patient care which has since gained widespread acknowledgment. Since then, Susan Lampe implemented Primary Nursing on her medical unit at United Hospitals in St. Paul.*

Each of the authors through their experience with Primary Nursing identified the need for a clearer definition of the Head Nurse role since leadership was observed over the years to be a key factor in the success of this innovation. Hence their philosophies, experiences, and enthusiasm have been combined to produce this article.

Vivian Good *is a native of Winnipeg, Manitoba and a graduate of St. Boniface School of Nursing in St. Boniface. She worked at the Manitoba Rehabilitation Centre before moving to Minneapolis to become a staff nurse in Medical Intensive Care at University Hospitals, University of Minnesota and a year later became head nurse on the Primary Nursing Unit. Since that time she has conducted numerous workshops on the topic and has been involved in private consultation in U.S. hospitals and now in Canada. Currently, she resides in Detroit Lakes, Minnesota where she works as an Adult and Geriatric Nurse Practitioner for Multi-County Public Health Nursing. She also holds a part-time position with the University of Minnesota Community Services Department and is in her last year of the Bachelor of Sciences in Health Services program at Moorhead State University.*

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Susan Lampe *R.N., is a graduate of Cornell University - New York Hospital School of Nursing, and is presently a graduate student at the University of Minnesota School of Nursing.*

References

1 Manthey, Marie. "Primary Nursing is Alive and Well in the Hospital," *Amer. J. Nurs.* 73:1, January, 1973.

A reading list is also available from the Canadian Nurses Association Library.

Answers

Clinical Wordsearch

Puzzle no. 4

1 Glomerulonephritis
2 Hydronephrosis
3 Catheter
4 Urine
5 Diuresis
6 Renal
7 Oedema
8 Proteinuria
9 Dialysis
10 Peritoneal
11 Nephron
12 Kidney
13 Tubule
14 Bladder
15 Calculus
16 Prostate
17 Frequency
18 Acid
19 Cystitis
20 Pain
21 Empty
22 Closed
23 Hypertension
24 Weight
25 Pyuria
26 Azotemia
27 Sodium
28 Transplant
29 Nephroptosis
30 Calcium
31 Parenchyma
32 Reject
33 Immunosuppressive
34 Suprapubic
35 Salt
36 Void
37 Pelvis
38 Tumor
39 Stones
40 Uric
41 Ureter
42 B.U.N.
43 pH
44 I.V.P.
45 Mg
46 I.N.H.
47 Fluid

Hidden Answer: Don't wink at acute pyelitis.

The leukemic child looks into the mirror provided by his peers who are sick like himself. The image of his future self that he sees reflected there provides him with the knowledge and understanding that he needs to cope with a life-threatening illness.

MIRRORING



Photo courtesy of Health and Welfare Canada

June Kikuchi

Illness, and especially hospitalization, subjects a child to a host of uncertainties. Will his mother return to visit? Will he get another needle? Will he die? A child with a life-threatening illness, such as leukemia, faces these uncertainties repeatedly. In addition, he is subject to numerous other uncertainties such as, "Will my hair fall out when I take this medicine? What will I look like bald? Will I be able to get a wig to suit me? Will the treatment work this time? Will anyone marry me now? How will I know when I'm going to die? Will my parents be able to stay with me, if I'm going to die?" Too many uncertainties can be intolerable. How then does the leukemic child deal with so many questions? One way is by reducing them to a manageable level through the use of "mirroring" — a process whereby the child, by identifying with and watching others, sick like himself, is able to see his future in them. For the child, it is like looking into a mirror and seeing a reflection of his future self.

While working as a clinical nurse specialist with leukemic children on an in- and out-patient basis throughout the course of their illness, I had the opportunity of observing their behavior. What follows is an account of how some of these children between the ages of nine and eighteen years used mirroring as one way of facing the uncertainties that beset them. All of them had ample opportunity to see other children with leukemia in the ward (which usually contained at least six children with leukemia at any one time) or in the hematology out-patient clinic. Some had been told that they had leukemia and perhaps its prognosis; others had been told that they had anemia or a blood disorder, etc. No matter what they had been told, they all seemed to get information from the child who looked like them and received similar treatment. He was the best teacher. The children used mirroring primarily to deal with uncertainties such as body mutilation and death, described elsewhere.

Uncertainties surrounding body mutilation

The leukemic child reduces his uncertainty about forms of body mutilation such as an intravenous infusion to a manageable level by watching other children. After he sees that others receiving intravenous infusion can move about, do things for themselves and are not badly mutilated, he is reassured.

For a child to be told his hair will fall out because of chemo- or radiotherapy is frightening. How will his hair fall out? What will he do without hair? How will he look? Will his hair really grow in again? To see what will actually happen to his body and how it can be fixed is reassuring. Truth is less traumatic than all kinds of terrible imaginings. For this reason, he seems to change his uncertainties to certainties by observing other children who have lost their hair and now wear attractive wigs. When he is informed that he, too, will lose his hair, he is upset and wants to be sure he can get a wig which will look like his own hair. He is further reassured by seeing children whose hair has already started to grow in again.

Loss of hair is of concern to the adolescent boy as it signifies loss of masculinity to him. To the adolescent girl, it represents loss of feminity. Another concern of the adolescent girl centers on how her disease will affect her ability to have a baby. She also wonders if the baby will be mutilated by her leukemic drugs.

●

As she approached the third year of her initial remission, **Lynn,** an amiable eighteen-year-old girl, asked the doctor if she would ever be able to have a baby. She wanted to know if the baby would be deformed by her drugs. The ensuing intellectual discussion did not seem to reassure Lynn. The doctor then talked with her about Kathy, a twenty-year-old girl who had had leukemia for five years. Lynn knew her and had identified with her in the past. When the doctor told her about Kathy's plan to have a baby when she came off her drugs in a half year, Lynn looked relieved. By identifying with Kathy, Lynn was able to change her uncertainty about her ability to have a baby to a certainty. If Kathy could have a baby, then she could also have one.

In this way, by watching what happens to others with a similar illness, the leukemic child gains information about how his body will be affected by the disease and treatment.

Uncertainties surrounding death

The leukemic children, especially those who were not told they had a life-threatening illness, came to suspect it from the necessity for frequent visits to the doctor, daily medications, various procedures, blood transfusions, and repeated hospitalizations.[2] They changed this uncertainty about the nature of their illness to a certainty by getting to know at least one other child who was sick like themselves. Later, when he died, their suspicion was confirmed. The children kept track of one another by writing or visiting their sick friends when they were hospitalized; they also asked about one another.

●

Judy, a bright, alert, nine-year-old girl was told she had anemia. She had two roommates, Sherry and David, both nearing the terminal phase of the leukemic process. Soon after Judy was discharged from the hospital she began to ask her mother how Sherry and David were. She knew her mother talked with their mothers. When told about David's death Judy was upset and asked, "What's going to happen to Sherry? David and Sherry have the same thing!" Each time she came to clinic, Judy would ask me how Sherry was. If Sherry was in the hospital, Judy visited her. When Sherry died, Judy's mother did not want her daughter to know, because David's death had upset her so. We later decided it would be better to tell the truth so as not to lose Judy's trust. Upon being told, Judy said that she would have kept asking as she knew something was going to happen to Sherry. She then cried, " I'm scared I'm going to die too. Sherry and I have the same thing." When asked why she thought so, she explained, "We take the same medicines. We both lost our hair." She had learned by mirroring, not by being told that she had a fatal illness.

●

Tim a quiet sixteen-year-old boy, rarely asked questions about his disease once the doctor had discussed it frankly with him. But when a leukemic child Tim knew died, he was anxious to talk about it; he wanted to know why the child had died. He also wanted to know if having leukemia would shorten his life span and he asked me what he could do to help himself.

Thus, by keeping track of one another, these children are able to confirm their suspicion that they have a life-threatening illness. If Nagy's belief[3] is true that at nine years of age a child achieves a realistic conception of death as a permanent biological process, then why would they want to confirm what seems to be a frightening suspicion? Probably because it is easier to face certainty than uncertainty. A known phenomenon can be grappled and dealt with while an unknown phenomenon cannot.

On the other hand, by keeping track of one another, the child can also confirm the suspicion that, although he may die, he can also live for awhile too. For example, the adolescent girl who has dreamt of marriage becomes especially worried about whether she will live long enough to get married.

●

Soon after **Sandi,** an inquisitive sixteen-year-old girl was found to have leukemia, she became friendly with Tom, another leukemic adolescent, who later died after being ill for four years. Sandi knew she had leukemia. After Tom's death, she was depressed and, no matter what she was told, talked about having only four years left. At the clinic, she met an attractive twenty-year-old girl who had had leukemia for five years and had just been married. Sandi shed her depression. She could identify with another girl who actually had lived for more than four years— someone who had married. Sandi began to be interested once again in dating, in getting married and in having babies.

However, sooner or later as the leukemic child becomes increasingly ill and the threat of death becomes more real, he wants to know when and how he will die and what will happen to him. Again he learns the answers from other children with a similar illness.

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Upon his second hospital admission, **Danny,** a fifteen-year-old adolescent who had been told he had a blood disorder, asked, "What's happened to Ralph, the boy who was in the room with me before? Did he go home? Why did his parents sleep here?" When he was told that Ralph and died, Danny said, "I wondered if he had made it. He didn't look so good. Is that why his parents slept here?" Danny then went on to talk about the possibility of freezing bodies until cures were found. He said calmly, "I know I'm incurable." A year later when his condition worsened and his parents stayed with him through the night at the hospital, Danny accepted without question what this meant.

Sometimes the child observes when and which child is moved into a private room and keeps close watch. On passing the room, he may glance quickly inside to see how the child looks and what is happening. Once the door remains closed for privacy and he is no longer able to see into the room, he watches who goes in and out and studies their faces. Occasionally he plants himself in the hall across from the room and keeps a vigil.

●

Trudy, a curious eleven-year-old girl who had experienced several relapses, was told she had a blood disorder. One day while we played a card game, a child on the ward died. In the middle of our game, I was called away. When I returned, Trudy was not in her room. A few minutes later she returned. She had gone, she said, to see if I had left the ward. When I mentioned that I had noticed that the door to Room 310 was open again, Trudy quickly and eagerly exclaimed, "Yeah, I saw that too! Did someone die in there?" When I said yes, Trudy said, "I thought so. I've seen people come out of the room crying." The card game was forgotten. She talked about how her mother had almost died giving birth to her but had seen Jesus and not been afraid. Later, Trudy asked for the meaning of the words "Blood Dyscrasia," an expression she had overheard. When I answered, "Disease of the blood," Trudy emphatically told me, "I'm not afraid to die you know. I've been saved."

Obviously Trudy had come to recognize what the opening and closing of a door to a private room could mean if people had come out crying. When children, like Trudy, have

made such deductions and have talked about their concerns, placing them in a private room when they are ill does not seem to come as a shock to them. In fact, they expect it and often ask for their own room.

● **Carol** a twelve-year-old girl who knew she would soon die from leukemia, asked her doctor if she could have a private room when she returned to the hospital. She had known several ill leukemic children who had been moved into a private room and died. She had decided she would like to stay at home until that moment she felt "bad enough to come to the hospital." Her second request was for her mother to sleep in the room with her at the hospital.

Some of the children are more eager than others to learn about what happens behind the closed door of a private room. This kind of information can only be obtained by asking, and the need to learn what might happen to them from other children's experiences is so great, they usually ask.

Where did her mother go? Did her mother stay with her?" We talked about all these things.

Besides wondering when and how he will die and what will happen to him, the leukemic child seems to worry most about whether his parents will be allowed to stay with him. The most comforting thing he learns from other children seems to be that, should he become very ill, his parents will sleep in the same room with him at the hospital.

Other children, like Danny have asked why certain parents remain overnight. Later, when they too become terminally ill, they like Carol, suddenly ask that their parents be allowed to sleep with them.

Another worry the child has is how his death will affect his parents. The adolescent is especially concerned about how much worry and trouble he is causing them. As he sees his parents becoming more exhausted, he worries about whether they will survive. What will happen to them? What will life be like for them without him? Will they miss him?



● **Janet** a frightened ten-year-old knew she had leukemia and often talked about the time she had been so sick she was expected to die. One day, after her afternoon nap, Janet saw Katy's name had been taken off the patient roster. She asked, "Where's Katy?" When she was told that Katy had died, Janet asked, "When did she die? Were her parents there? Do the nurses know Katy died? They act as if nothing's wrong! How does Katy's nurse feel? How did her nurse know Katy died? What's going to happen to the teddy bear she always carried? Are they going to bury it with her or is her mother going to keep it? How did the nurses get Katy out of her room? Where did they take her?

● **Pat,** a vivacious thirteen-year-old girl who knew she was in her first leukemic remission, continued to write and visit the family of a leukemic friend who had died. She enjoyed this contact and commented on how nice it was to see that Andy's family still remembered him, had pictures of him, talked about him, and missed him. She was glad to see how well his parents were coping and that they had "not fallen to pieces."

It must be comforting for a child who may be concerned about how his family will survive without him to see that, if he dies he will be missed but that his family will not disintegrate.

Helping the leukemic child to use mirroring

By identifying with children who are ill like himself, and by watching what happens to them, the leukemic child is able to see his future self in others and thus reduce the number of uncertainties facing him to a level he can tolerate. Instead of imagining all kinds of unreal situations he is able to see for himself what might happen.

- If he loses his hair, he can get an attractive wig and his hair will indeed grow in again.
- He can tell how ill he is by whether he is moved to a private room.
- He knows he will have a nurse and his parents stay with him when he becomes very ill.

Having seen all these things taking place, the leukemic child does not at first feel the need to ask a lot of questions about himself. Instead, he is able to take in everything at an emotionally safe distance, that is, one step removed.

It is important for staff members caring for the leukemic child to be aware that mirroring *does* take place and that this is the child's indirect way of clarifying his own situation. They should realize just how much this vicarious experience means to him. *But mirroring is a process that the child should be allowed to carry out on his own.* The child himself must be allowed to control what he wishes to see and what he wishes to deny. Staff members can best assist him by being available to help him deal with questions and concerns aroused by an experience and to detect and correct any misconceptions he might have formed, not by pushing him to see what he does not want to see.

Author **June Kikuchi's** *experience includes five years as clinical nurse specialist at the Hospital for Sick Children in Toronto where she worked specifically with leukemic children and their parents. In this position she initiated care of these children after their diagnosis and then, with staff, continued to care for them throughout the course of their illness.*

June Kikuchi, R.N., B.Sc.N., M.N., is now in her second year of clinical doctoral studies in the Nursing Care of Children program at the University of Pittsburgh in Pennsylvania. Her studies are funded by the Hospital for Sick Children Foundation. A graduate of the University of Toronto, School of Nursing she received her M.N. from the University of Pittsburgh School of Nursing after being awarded a scholarship from the Canadian Nurses' Foundation.

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Frankly Speaking

SPECIALIZATION IN NURSING

Eleanor G. Pask

In the past few decades, nursing has functioned in the midst of a world that is increasingly geared to specialization. Sophisticated technology and burgeoning scientific knowledge have succeeded in widening the scope of our profession. Yet nursing has tended to favor a pattern of generalization and has been slow to promote specialization, especially in the clinical field, among its members. For the most part, the development of specialization within the profession has emerged with little planning.

Now, however, the need for specialization is at last beginning to be recognized and a variety of specialties are emerging. Nurses must take their cue from the other professions: those of us who want to specialize must identify ourselves and be recognized as activists — aware of our goals.[1]

The emergence of a specialty follows a recognizable pattern:
1. development of specialist knowledge
2. application of that knowledge
3. the choice of those with special interest and aptitude to work in that area.

In nursing, as in medicine, the rapid expansion of information makes it increasingly difficult to include specialty instruction in basic programs. It seems likely that, in the near future, we will be expected to take specialty training before we can work in special units. The problem is that, as yet, the education system is not geared to meet this expectation.

- *The need is known*

In 1925, Goldmark[2] stated that a nurse should be able to specialize to meet the demands of advances in medicine and technology, and in 1932, Weir[3] added that opportunities to do this must be made available. But nurses have not accepted the challenge. In 1967, Murray[4] decried the apathy within the nursing profession concerning the lack of organized specialty training for graduate nurses.

At its 1970-72 biennial meeting, the Canadian Nurses Association (CNA) identified specialization in nursing as one of its priorities for action. Simultaneously, a nation-wide survey of Canadian nurses[5] confirmed the need for training in the specialties: the concensus favored the use of educational institutions rather than hospitals for such courses, and stated the need for recognition of the special competencies achieved through these courses.

- *Is certification the answer?*

Many specialty groups in the United States provide specialty training, and certification to Canadian nurses because equivalent courses are not available in Canada. Thus, Canadian nurses working in operating rooms, dialysis units, and emergency departments, for example, may take American courses. But, the certificate they earn is not officially recognized in Canada.

In 1958, the American Nurses' Association (ANA) set a goal: "To establish ways ... to provide formal recognition of personal achievement and superior performance in nursing." [6] During the next 15 years, many specialty groups developed, offering education and certification to their members. The ANA now has seven such programs, including geriatrics, psychiatry, pediatrics, medicine/surgery, community health, and a combined course in obstetrics/gynecology and neonatology.

Originally, the term 'certification' implied excellence and an advanced level of training. Now, however, with the proliferation of specialty groups, it can mean anything from minimal standards to the highest level of achievement. There has developed a gradual recognition of this disparity in the use of the term 'certification', and a growing awareness of the conflict between the goals set by the ANA and specialty groups. In trying to resolve their differences, they are working toward the standardization of certification. For example, the Nurses' Association of the American College of Obstetricians and Gynecologists (NAACOG) recently merged with the nurses' parent body, to form the ANA-Maternal-Gynecological-Neonatal Nursing Specialty, and the O.R. Nurses' Association proposes to form a similar association.

- *Obstacles to specialization*

Nurses as a profession have been described in uncomplimentary terms —terms such as apathetic, moribund, and confused.[7] We should be indignant at such a description (moribund we certainly are not, and apathetic and confused we hope we aren't) — but when this comment was made it provoked little response from nurses. However, this statement was made from outside the nursing profession, and it's an old truth that outsiders can sometimes see the problem more clearly. So we must ask: how accurate is this description? In view of the lack of response, obviously we are apathetic. We have been confused, too, but hopefully, we are beginning to sort out the facts.

What are the obstacles, other than apathy, to specialization in nursing? Certainly, there are few incentives. Hospitals have assumed almost complete responsibility for nurses' *clinical* graduate training in the specialties(*i.e.*, working on specialty wards), but they rarely include instruction in essential background knowledge and theory. The nurse

Frankly Speaking is intended as a forum for nurses who want to speak out on issues that may influence the future of nursing practice, research, administration or education. Guest columnists from time to time will be members of the Board of Directors of your national professional association. If you have an opinion or concern that you would like to share with your fellow nurses, why not write to us. This is your chance to get involved, to participate in shaping the destiny of your profession.

no plans to attend a course must accept that obably her colleagues will resent her sence, because of the additional work for em. Few hospitals reimburse a nurse for king a clinical course; they may approve ave of absence — usually unpaid — but ovide few bursaries or scholarships. Thus, ditional training may cost a nurse thousands dollars, for tuition, lost wages, and often, keep in another city. Even then, on her turn to work, her hard-won training may go recognized both officially and financially. ome nurses even find that the jobs for which ey trained have been filled in their absence.

So, the great majority of nurses continue provide the best patient care they can, even t the expense of their own further education.

Solutions

Today, basic nursing performance tandards are available. The next move must e made by the specialty groups which, with he guidance and support of provincial rofessional associations, must define niform, high standards for specialty training. epresentatives of the provincial ministries of ealth and the nurses' associations should ssess the status of nursing specialization, to etermine needs and, along with epresentatives from community colleges and niversities, develop specialty courses and niform certification standards. The entire rocess should be co-ordinated, supported nd interpreted by our national association CNA) to ensure the same high level of ompetence throughout Canada. Such ourses should be presented by educational nstitutions in collaboration with their affiliated ospitals.

There should be a register of nurses, with nention of specialty certification, as in a nedical directory. This could be compiled — gain, as for doctors — from short uestionnaires completed for annual egistration. The programs should be onducted jointly by the CNA and the rovincial specialty groups.

Ensuring continued competence resents another problem, but with a current entral registry this could be achieved by equiring endorsement by colleagues, and etesting, at regular intervals for example, very five years.

Conclusion

Inevitably, nursing will become more specialized: the groundwork has been laid, the need has been documented repeatedly, and now we are ready to move into planned specialization.

Most important is the need to define, encourage, and recognize specialization; as a profession we should be working towards it *now*. The change will take some time, but we must begin to consider attendance at nursing meetings and education courses a necessary part of our continuing education.

As a profession, where do we want to go? How do we want to get there? If specialization is what we need, and certification is what we want, we must complain more vociferously about the obstacles and start removing them.

Eleanor G. Pask *(B.Sc.N., R.N.) is Head Nurse in the Clinical Investigation Unit at The Hospital for Sick Children in Toronto.*

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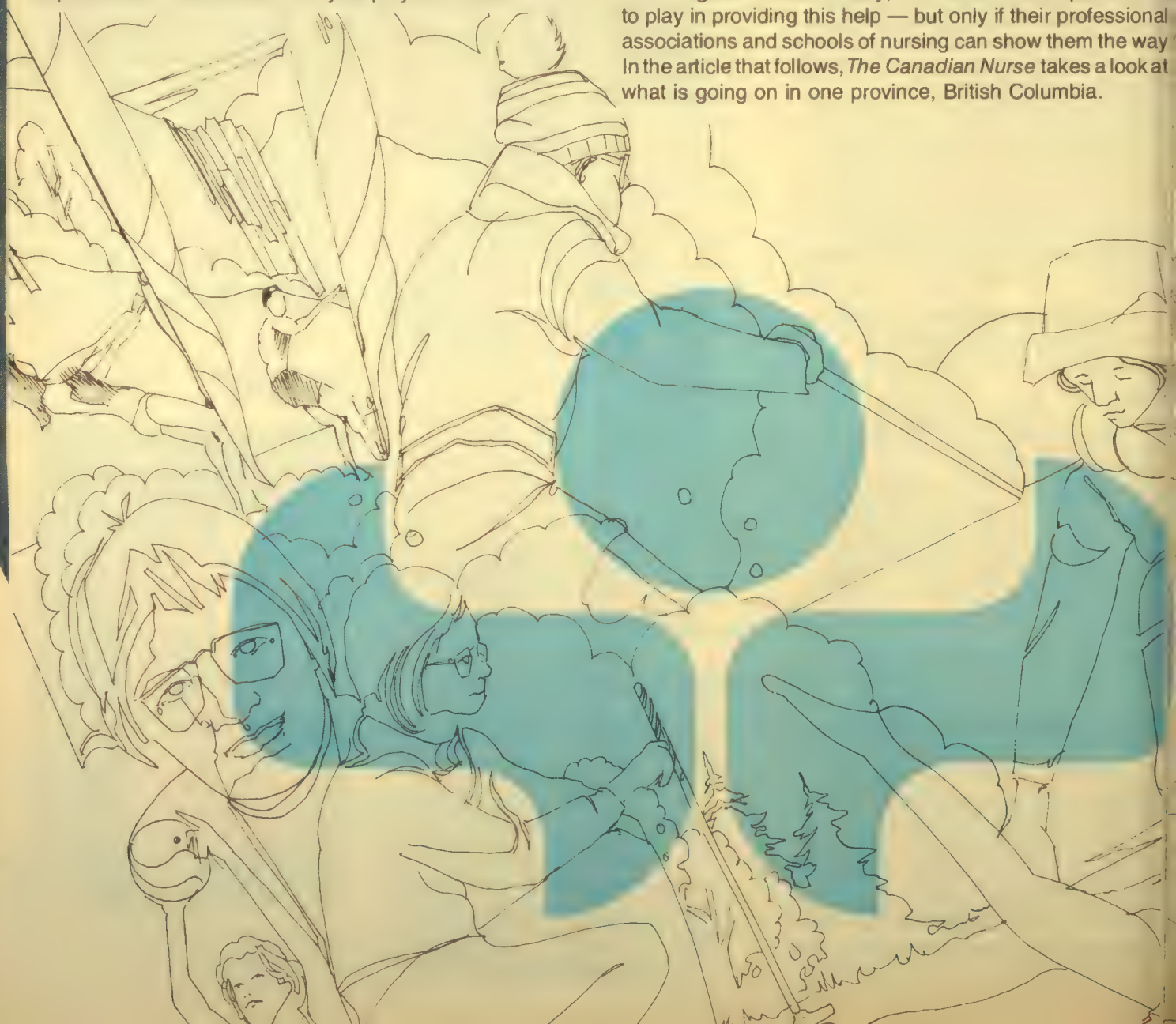


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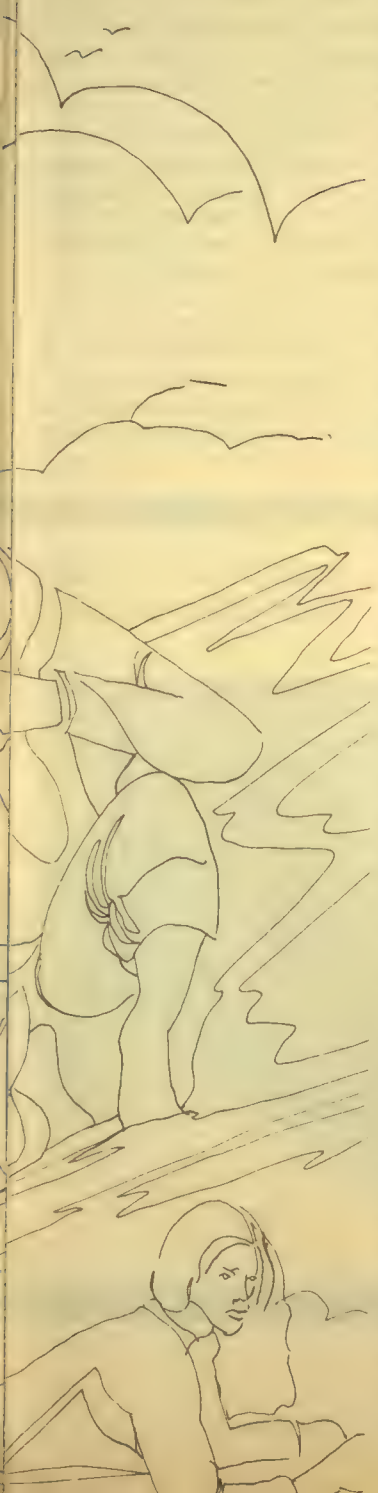
Since the publication of Marc Lalonde's *A New Perspective on the Health of Canadians* in 1974, a public debate has ensued about the many health hazards that are self-imposed — obesity, lack of fitness, alcohol and drug abuse, smoking, etc. The media have helped to awaken the public to the importance that individual lifestyles play on health.

Participaction posters in buses and subways, television and radio advertisements about non-smoking and fitness all emphasize health promotion. Increased awareness has prompted many people to seek better and healthier patterns of living and it is to the health professions that these people look for guidance. Obviously, nurses have an important role to play in providing this help — but only if their professional associations and schools of nursing can show them the way. In the article that follows, *The Canadian Nurse* takes a look at what is going on in one province, British Columbia.



From the time a few years ago when many traditional hospital schools of nursing transferred to the community college setting, some employers have voiced the opinion that the two-year-diploma graduate is not "experienced" enough. Does this mean that the graduate has not had enough clinical practice to have developed manual dexterity... or that she is unable to cope with a realistic patient load... or that she is not confident in her nursing care? Whatever the interpretation, the concern exists and one community college that is trying to do something about it is Okanagan College in British Columbia. What follows is an explanation of the philosophy and implementation of the diploma nursing program at that college.

Judith M. Skelton



Preparation of nurses with RN certification has passed through many stages since Florence Nightingale introduced gentlewomen into the profession of nursing during the Crimean War. Early schools of nursing were established in hospital settings, with no standardization of curriculum content, clinical facilities or entrance requirements. Nearly every hospital, regardless of size, conducted a training program since by doing so it was assured of a continuing supply of low cost staff. In fact, however, the graduates of such programs nearly all went into private duty where the hours and pay were more reasonable.

The introduction of registration for nurses in the early 1900's in Canada marked the beginning of a long, slow process of standardization of the educational prerequesites for affixing "RN" after one's name. Until fairly recently, these educational requirements tended to be expressed in terms of the number of hours spent in a given setting rather than in terms of what competencies were developed — hence the idea that "it takes three years to become a nurse."

Twenty-five years ago, Mildred Montag spearheaded the development of "associate degree" nursing programs that were based in U.S. community colleges. Community colleges, as they have developed in Canada and the U.S., are the logical setting for basic nursing education. They provide a post-secondary level education with a practical orientation, that leads to employment opportunities and/or university transfer. Because college nursing students are not required to provide service to a hospital, their clinical experiences can be more closely correlated with classroom learning and the overall course of study can be accomplished in a shorter period of time — hence the notion of "two-year college programs."

In British Columbia, as in most parts of Canada, nursing education has traditionally taken place in hospital-based programs. This trend began to change when the British Columbia Institute of Technology (BCIT) instituted a nursing diploma program in 1967. In the early 1970's, an increasing number of community colleges throughout Canada offered nursing programs to students. To date, all of the hospital-based programs in B.C. continue to be three years in length while the college-based programs are two years. In contrast, in Ontario, until recently, there existed many two-year hospital-based programs which have all since moved into community colleges, while in Quebec, the CEGEP nursing programs are three years. But while the question of two-year versus three-year programs continues to be hotly debated, perhaps what we really ought to do is decide what competencies beginning RNs require and then decide how long and in what manner these competencies are best acquired.

The competencies required of beginning RNs will, of course, change with the changing health needs of society and education programs will have to be flexible enough to adapt. Anticipating these changes, Okanagan College in Kelowna, B.C. has launched a new diploma nursing program which has some unique features. These features include:

- focus on the nurse as a health promoter
- a three dimensional curriculum framework
- a cooperative education design.

Program Objectives

It is anticipated that the graduate of the Diploma Nursing Program at Okanagan College will be prepared to:

- assume a beginning staff nurse position in an acute, intermediate or extended care hospital, clinic, office or home care setting;
- work under the general supervision of an experienced registered nurse. The more experienced nurse should be able to answer questions and give general direction to the new graduate. In fact, it is hoped that graduates of the Okanagan College program will require less supervision, direction and support than other college graduates, as a result of having had "real work" experience in the course of their training.
- work within a framework of written policies and procedures;
- provide non-specialized, health-oriented nursing care to a group of patients. It is our belief that preparation for specialization is beyond the scope of a diploma program.
- write the provincial nurse registration examinations.

Within this context, the graduate will consistently:

1. Communicate effectively with patients and colleagues.

— demonstrate skill and sensitivity in human relations and communication
— demonstrate skill in health teaching
— provide leadership in small groups of clients and auxiliary nursing personnel
— collaborate with other health team members in the provision and coordination of quality care.

2. Provide quality nursing care to one or more patients requiring non-specialized* nursing intervention.
— use the nursing process to provide individualized nursing care to patients: gather data, identify actual and potential needs-for-help, set priorities, plan, implement, and evaluate nursing care
— involve the patient and his significant others in the plan of care
— demonstrate skill and confidence in the application of non-specialized nursing measures.

3. Demonstrate professionalism in the delivery of nursing care.
— seek to maintain and improve the health of self and patients
— act as a patient advocate
— exercise professional rights and responsibilities
— demonstrate an open-minded and constructive attitude toward changes in health care and nursing practice
— assume primary responsibility and accountability for maintaining one's own competence in nursing practice.

While these objectives may not appear to be especially unique for a nursing curriculum, the way in which we fulfill the objectives *is* rather unique.

The Nurse as a Health Promoter

The promotion of health is a current and important topic of discussion among all health professionals. When Canada's present health care system was established, the causes of death and disease in the population were markedly different from what they are today. The current situation shows that "diseases of excess" due to alcohol and drug abuse, smoking, overeating, lack of exercise, etc. probably account for 50% of illness in our society. Besides this, escalating costs for health services demands that a less expensive approach to health — an alternative to the "disease orientation" — be found. People are becoming increasingly aware that they are not at their optimum level of health and are beginning to seek direction and guidance in improving this situation. The health professional of the future must take some responsibility for giving this direction.

Accordingly, a primary focus of the total nursing program at Okanagan College is on the role of the nurse in health promotion. Fundamental to this approach is the idea that the *nurse* must be a good role model of health. Therefore, it is expected that both students and faculty be actively engaged in improving their own health status.

Curriculum

The framework or foundation for our nursing curriculum may be visualized as a cube. In the first dimension are those qualities which nursing students must develop. These include effective communication, a logical and effective approach to nursing care, and professionalism. In the second dimension are the various stages of life with which nurses must be familiar. These stages include infancy, early childhood, middle childhood, adolescence, early adulthood, middle age, and later maturity.

Finally, nurses must have a focus for the nursing care they provide. At Okanagan College, we view man as a being who is constantly responding to stimuli. These stimuli arise from three sources: from his development, from his lifestyle, and from unpredictable events. Some of his responses to these stimuli will be healthful, and others unhealthful. It is the nurse's role to try to increase the number or quality of healthful responses.

Growth in all three dimensions of this framework is planned to occur simultaneously throughout the program. As the students tackle new concepts in nursing care, they will move from:
simple — complex
general — specialized
health — illness
single patient — multi-patient
single problem — multi-problem
team member — team leader.
Clinical practice will be concurrent with classroom work throughout to allow immediate application of new knowledge.

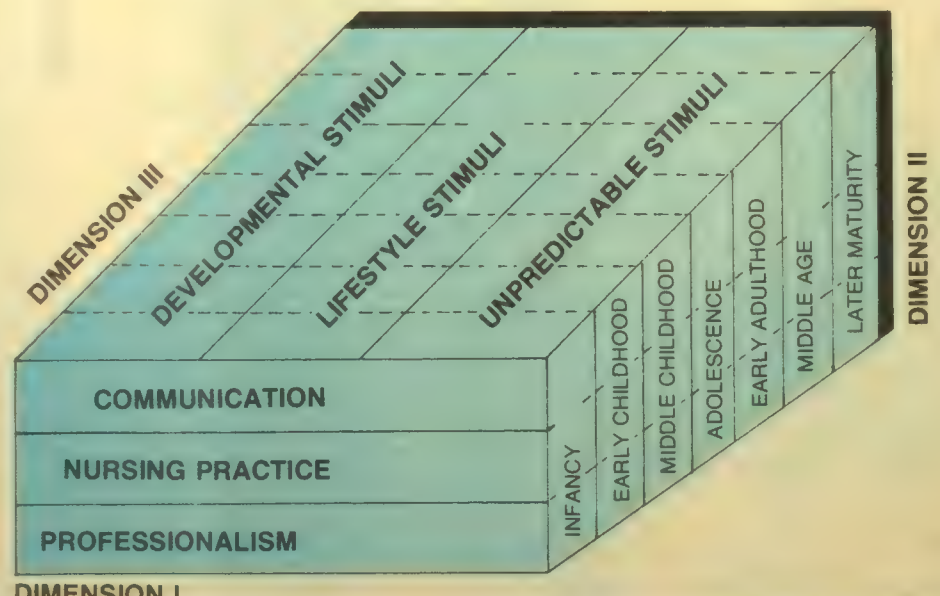
Cooperative Education

Over the past several years, employers have voiced concern that graduates of two-year diploma nursing programs "haven't had enough clinical practice." It is difficult to know precisely what is meant by this phrase — one person may mean not enough practice to have developed good manual dexterity; another may mean not enough practice to be able to cope with a realistic patient load; a third may mean not enough practice to be self-confident in giving nursing care; and still another may mean not enough practice to be able to function in various specialty areas. Whatever the specific meaning, the concern is very real.

In an attempt to deal head-on with this problem, we have lengthened the Okanagan College program to two-and-one-half years and adopted a Cooperative Education Design. To my knowledge, this is the only nursing program in Canada to utilize such a design although universities such as the University of Waterloo in Ontario are using a similar scheme for other programs such as engineering. A very few American nursing programs have experimented with this concept.

Cooperative Education is a college program within which students are employed for specific periods of off-campus work as a required part of their academic program. This employment is related as closely as possible to the student's course of study and individual interest.

Framework for the Nursing Curriculum



*Non-specialized nursing care — the nursing care of infants, children and adults exclusive of that required by critically ill or high risk patients. (Definition adopted from Draft Statement of RNABC Task Committee to identify critical components of a Basic Nursing Program)

Cooperative Education schemes are motivated by the belief that education ought to prepare students, not only for a specific job, but also for the growing and adapting they will have to do. Work experience rounds out education, eases the progression from knowledge to performance, and satisfies the need for reality in learning.[1]

The Board of Directors of The National League for Nursing (1972) emphatically stated that in order to prepare the qualified personnel needed for the future, nursing education must become more flexible and provide increasing amounts of cooperative and collaborative arrangements for nursing education. A Cooperative Education design provides these dimensions.

In addition to receiving the clinical instruction which is a required part of all nursing education curricula, cooperative nursing students have the opportunity to consolidate their nursing knowledge and skill while observing and participating in current methods of health care. This experience leads to more competent and confident graduates who are better able to cope with the realities of their work situations, and avoids the "Reality Shock in Nursing" which has received so much attention of late.

Our students will attend Okanagan College during the regular fall and winter semesters for 2 1/2 years. During these "study semesters" they will take health science, nursing and non-nursing support courses, complemented by an average of two days per week clinical practice. In the summers the students will enter 12-week "work semesters" during which they will work a full shift rotation, carry a realistic patient load and generally consolidate the knowledge and skills acquired in the previous two study semesters. We believe that the work semesters will assist our students to:

(a) demonstrate better manual dexterity;
(b) carry a more realistic case load; and
(c) be more self-confident

than graduates of traditional College programs.

In the first work semester the students will be hired as summer relief staff by local hospitals. They will replace ancillary nursing personnel who are on vacation. The students will function as hospital employees according to a job description which is mutually satisfactory to the institutions and the College. They will be paid nurse's aide wages in accordance with the B.C. Hospital Employees Union contract. The students will not receive direct supervision from a College faculty member. However, someone from the College will be "on call" to assist the students and/or employers to work through any problems or concerns.

In the second work semester — due primarily to the difficulty in determining within whose jurisdiction the students would fall — the students will serve a preceptorship. Each student will be assigned to a competent RN for the semester. The student will work the same shift, have the same days off and share the duties and responsibilities of the graduate. He/she will remain a student and will receive indirect supervision from a College instructor. Students will not be paid by the hospital during the second work semester but will continue to receive the provincial government monthly stipend which at present is $150.00.

Summary

In summary, we have attempted, in planning the Diploma Nursing Program at Okanagan College, to retain the positive aspects of existent hospital and college programs, while at the same time developing some unique features: a health promotion focus, a comprehensive curriculum framework and a cooperative education design. As yet, in this first year of the program, it is too early to predict outcomes, but we anticipate that our students will be better equipped to deal with the reality of a work situation.

Judith M. Skelton received her B.S.N. from McMaster University, Hamilton, Ontario in 1969 and her M.S.N. from the University of British Columbia, Vancouver in 1973. She has had experience in general duty and public health nursing as well as teaching experience in two, three and four year nursing education programs. At present, she is the Co-ordinator of Nursing Education , Okanagan College, B.C.

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Cooperative Education Design for Nursing Program

	Fall	Winter	Summer	Fall	Winter	Summer	Fall	
	STUDY SEMESTER NO. 1	STUDY SEMESTER NO. 2	WORK SEMESTER NO. 1	STUDY SEMESTER NO. 3	STUDY SEMESTER NO. 4	WORK SEMESTER NO. 2	STUDY SEMESTER NO. 5	



Adopted as an official position paper by the Board of Directors of

The nurse's role in health assessment and promotion

The promotion of health is a current and important topic for all health professionals. Causes of death and disease in today's civilized world are markedly different than when our present health care system was established. Costs of illness care in Canada are rising at truly intolerable rates. A less expensive approach to health is not only desirable, but necessary.

Lay people are becoming aware of their lack of wellness and are seeking direction in selecting a path to better health. Many entrepreneurs have capitalized on this situation by providing false and often expensive guidance. To assure relevance to the health needs of today, health professionals must accept that they have a role to play in giving direction to the "worried well."

☐ Philosophical Assumptions

The philosophical assumptions guiding this paper on the nurse's role in health assessment and promotion are as follows:

1. Health, a dynamic process occurring throughout the life cycle, implies continuous adaptation of lifestyle to anticipated and unanticipated events.
2. Health implies the selection and utilization of individual, family and community resources. Each person has both the right of access and the responsibility to use these resources to maintain his health.
3. An individual's values and attitudes about health can be changed by life experiences and/or interaction with significant others. Nurses, as members of the health care team can be the significant others, and in that way contribute to a person's health assessment and promotion.
4. The nursing process is an interpersonal problem-solving approach which is used for the assessment and promotion of a person's health.

☐ Definition of Terms

Health: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity;[1] "not only adding years to our life, but life to our years."[2]

Health Assessment: a systematic process of collecting and interpreting information relative to an individual's state of physical, mental and social well-being.

Health Promotion: a process which encourages individuals to adopt a lifestyle compatible with optimal health.

Lifestyle: an individual's habitual and characteristic pattern of living.

Optimal Health: the highest degree of physical, mental and social well-being achievable by an individual at any given time.

Stress: a physical and emotional state always present in the person, intensified when environmental change or threat occurs internally or externally to which he must respond.[3]

Nursing: The RNABC in its Position Paper on Nursing Practice, accepted the following definition of nursing:

The unique role of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge.[4]

This association feels that this definition, by its inclusion of the words "well" and "health," clearly identifies the fact that a significant part of nursing care is health promotion.

Giving further weight to this concept is Marc Lalonde's exposure of the facts that:

self-imposed risks and the environment are the principal or important underlying factors in each of the five major causes of death between age one and age seventy ...[5] and

diseases of the cardiovascular system, injuries due to accidents, respiratory diseases and mental illness, in that order, are the four principal causes of hospitalization, accounting for some 45% of all hospital days.[6]

Lalonde further states:

one can only conclude that, unless the environment is changed and the self-imposed risks are reduced, the death rates will not be significantly improved.[7]

It seems safe to assume that morbidity statistics will not alter unless these factors are dealt with as well. As one strategy for improving the overall health of Canadians, Lalonde suggests:

The continued extension of the role of nurses and nurse practitioners in ... counselling on preventive health measures, both mental and physical, and in the abatement of environmental hazards and self-imposed risks.[8]

☐ Principles

Two principles form the basis for this paper:

1. Nurses must accept responsibility for optimizing their own health.
2. Nurses must accept their role and responsibility to sensitize others to the need to optimize their own health.

Health assessment is the first step in any program or plan for health promotion. Health assessment is defined as collecting and interpreting information relative to an individual's state of physical, mental and social well-being. Effective health assessment requires knowledge and skills on the part of the nurse, appropriate technology, and inter- and intra-professional cooperation. The range of skills is wide, including manual, managerial, attitudinal and communicative aspects.

Health promotion is defined as a process which encourages individuals to adopt lifestyles compatible with optimal health. To be effective as a health promoter, the nurse first must be a role-model of health. Moreover, she must have special knowledge and skills, access to appropriate technology and resources, and an ability to collaborate with other health workers.

☐ Functions

All practicing registered nurses should perform at least the following functions in relation to health assessment and promotion.

Health Assessment:[9]

1. Assessment of physical status
2. Assessment of psycho-social status
3. Assessment of lifestyle status.

Health Promotion:

1. Be a role-model of health
2. Act as a change agent with/for patients
3. Encourage lifestyle activities compatible with optimal health
4. Collaborate with other health workers in providing health-oriented care
5. Support those policies, procedures and activities which promote health.

According to their level of interest and preparation, individual nurses may take more active roles in health assessment and promotion. Table A contains one suggested format for obtaining appropriate data relative to self and patients, regardless of the setting in which they are found. A variety of other appropriate assessment tools are also available. Table B contains a suggested list of activities which nurses may perform in promoting health.

In conclusion, that nurses have a role in health assessment and promotion seems hardly a matter for debate. The problem is preparing and encouraging nurses to fulfill this role. To this end, the following recommendations have been approved by the RNABC Board of Directors:

— That the RNABC officially adopt the Position Paper on the Nurse's Role in Health Assessment and Promotion.

— That the position paper be published in *RNABC News*; moreover, that it be widely circulated to other nurses and related health workers.

— That funds be allocated in the RNABC budget to assure that the role of the nurse in health assessment and promotion be properly initiated (e.g. continuation if appropriate of the 1976 project designed to sensitize members to their role in health promotion).

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Table A Health Assessment

1. Assessment of physical status, including:

1.1 state of growth and development
- a. physiological developmental tasks to be accomplished at this stage

1.2 circulatory status
- a. character of pulses
- b. character of blood pressure
- c. movement of fluids (e.g. edema)

1.3 respiratory status
- a. character
- b. interference with respirations

1.4 fitness status
- a. fitness test
- b. health hazard appraisal

1.5 motor ability status
- a. current mobility status
- b. posture
- c. range of joint motion
- d. muscle and nerve status
- e. coordination

1.6 status of physical rest and comfort
- a. sleep and/or rest pattern
- b. presence of pain, discomfort, restlessness, etc.
- c. use of supportive aids

1.7 nutritional status
- a. condition of buccal cavity
- b. ability to masticate
- c. ability to swallow
- d. appetite
- e. ingestion of nutrients
- f. digestion of nutrients
- g. weight

1.8 elimination status
- a. bowel
- b. bladder

1.9 reproductive status
- a. external genitalia
- b. age at menarche
- c. pattern of menses
- d. pregnancies
- e. breasts

1.10 body temperature status
- a. range

1.11 status of skin and appendages
- a. skin
- b. hair
- c. nails

1.12 status of special senses
- a. hearing/speech
- b. vision
- c. taste
- d. smell
- e. touch

2. Assessment of psycho-social status, including:

2.1 stage of growth and development
- a. age
- b. psycho-social developmental tasks to be accomplished at this stage

2.2 demographic status
- a. sex
- b. marital status
- c. relatives
- d. occupation
- e. financial status
- f. housing

2.3 ethno-cultural status
- a. race
- b. ethnic origin
- c. religion

2.4 mental status
- a. state of consciousness
- b. orientation
- c. intellectual capacity
- d. insight into health status and/or problems

2.5 personal status
- a. motivation/readiness
- b. strengths, weaknesses, limitations
- c. stress factors
- d. risk factors
- e. sexuality

2.6 interpersonal relationship status
- a. family
- b. significant others

3. Assessment of lifestyle status

3.1 effects of daily habits

3.2 effects of work

3.3 effects of culture

3.4 effects of home and work environment

3.5 commercial products and/or environmental circumstances detrimental to health

Table B Health Promotion

1. Be a role model for health

1.1 maintain physical health
- a. undertake an appropriate physical activity program
- b. cope with stress
- c. avoid harmful products and circumstances
- d. ensure proper nutrition
- e. keep immunization current
- f. have regular check-ups
- g. plan for relaxation and sleep

1.2 maintain psycho-social health
- a. strive for positive interpersonal relationship
- b. increase self-esteem
- c. avoid harmful circumstances
- d. select health/role-models
- e. have regular check-ups
- f. anticipate developmental tasks rather than just living in the here and now

1.3 adopt a healthy lifestyle
- a. cope with stress
- b. avoid harmful products and circumstances
- c. adjust own concepts of health and fitness
- d. set realistic goals, priorities, guidelines
- e. assume accountability for own health

2. Act as a change agent with/for patients

2.1 use appropriate motivational approaches
- a. establish a trusting relationship
- b. increase clients' self-esteem
- c. identify and enlist support of significant others
- d. contact
- e. participate
- f. induce anxiety and/or guilt

2.2 get patient commitment to change

2.3 assist in the formulation of realistic goals and priorities

2.4 reinforce health responses

2.5 provide anticipatory guidance for each life stage

3. Encourage lifestyle activities compatible with optimal health
- a. appropriate physical activity program
- b. adequate rest and relaxation
- c. avoidance of harmful products and circumstances
- d. identify and cope with stress
- e. regular check-ups
- f. fluoridation
- g. good hygiene
- h. proper nutrition
- i. current immunization
- j. appropriate management of chronic disorders
- k. appropriate use of community resources
- l. accountability for health maintenance

4. Collaborate with other health workers in providing health-oriented care
- a. know own role and limitation
- b. refer appropriately
- c. cooperate

5. Support those policies, procedures and activities which promote health
- a. health-oriented institutional philosophies
- b. health standards and guidelines
- c. health-oriented institutional policies, procedures and routines
- d. health-oriented evaluation procedures and criteria
- e. health-oriented community and political involvement

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FETAL MONITORING

An increasing number of hospitals in North America are buying fetal monitors for the purpose of assessing fetal health just prior to delivery. There are many who see the use of the electronic device as a means of reducing North America's high perinatal mortality rates. However, continuous electronic fetal monitoring has its critics: those who term it an 'expensive gadget', those who say it increases the primary cesarian section rate, that its recordings are difficult to interpret, that it constitutes a risk to mother and fetus, or that it depersonalizes the relationship between an obstetrical nurse and her patient. Are fetal monitors worth the money, time, training, and risks involved?

Ellen Hodnett

Critics of electronic fetal monitoring are adamant in their stand against its use. No one, they say, has proven that monitoring lowers perinatal mortality rates, adding perhaps that disadvantages to its use far outweigh assets, or that it only benefits high-risk patients. Many hospitals buy the expensive equipment to let it sit alone and rarely used in an unobtrusive corner of the labor and delivery suite.

What about the proponents of fetal monitoring, those actively involved in its use? As a labor and delivery nurse and instructor to undergraduate students in maternal and infant health, I felt that it was important to investigate what they had to say.

I set out to answer the questions raised by fetal monitoring by reading about the experiences of those who use it in a variety of hospital settings in North America. This article is based on the writings of those involved in fetal monitoring and associated research.

Ways and Means

Continuous electronic fetal monitoring involves the use of direct or indirect techniques to measure and continuously record both the fetal heart rate and the activity of the uterus during labor.

The indirect method of fetal monitoring involves the use of two devices to be placed on the mother's abdomen during labor: a tochodynamometer to indicate the frequency and duration of uterine contractions and a transducer to measure fetal heart rate.

The technique is non-invasive, with no inherent risks to mother or fetus. It can be used before the rupture of the membranes, and throughout all stages of labor.

There are some problems evident with the use of indirect fetal monitoring. If the patient is obese or restless, it is often difficult to obtain a clear monitor tracing. Some patients find it uncomfortable, and too restrictive to their freedom of movement. The information derived from indirect fetal monitoring is somewhat lacking in two specific areas: it gives no data on beat-to-beat variability, an important indicator of fetal welfare; it provides no information on the strength of uterine contractions or on the resting tone of the uterus.

The direct method of continuous fetal monitoring is an invasive method. A uterine catheter is inserted around the presenting part of the fetus and lies floating in the uterine cavity to measure the tonicity of the uterus. A spiral electrode is attached to the presenting part of the fetus to record the fetal electrocardiogram.

Direct fetal monitoring provides more specific data than the indirect technique and allows the patient more comfort and freedom of movement. However, the method is not without limitations. First, the membranes must be ruptured, the cervix one to two centimeters dilated, and the presenting part of the fetus no higher than -2 station. Secondly, there are risks to both fetus (such as neonatal scalp abscess) and to mother (such as uterine perforation), fortunately rare in occurrence. The procedure requires practice and technical skill on the part of the obstetrician inserting the catheter and electrode. Regardless of the type of monitoring used, fetal heart rate deceleration patterns do provide information about the welfare of the fetus. There are three significant deceleration patterns to watch for.

1 ***Early deceleration*** is thought to be due to fetal head compression during contractions. The degree of heart rate slowing generally reflects the intensity of the uterine contraction. Early deceleration is usually a benign pattern, transitory in nature and apparently well-tolerated by the fetus.

2 ***Late deceleration*** is thought to be due to utero-placental insufficiency and is ominous. It is frequently associated with high-risk pregnancies, uterine hyperactivity, and/or maternal hypoxia.

3 ***Variable deceleration*** is thought to be due to umbilical cord compression. It is also a pathologic pattern, but it can often be alleviated by changing the mother's position.

why bother?





1973 Perinatal Mortality Statistics *

(per 1000 live births)

Sweden	14.1	Canada	17.7
Denmark	14.6	Japan	18.0
Switzerland	15.5	England and Wales	21.3
Iceland	16.3	Australia	22.4
Netherlands	16.4	Scotland	22.7
Norway	16.8	Federal Republic of Germany	23.2
Hong Kong	17.6		

* World Health Statistics Annual Vol. I, Vital Statistics. Geneva, Switzerland, World Health Organization 1973-76, Table 5, pp. 15-18.

Beat-to-beat variability can only be assessed through direct monitoring techniques. This term refers to the degree of short-term fetal heart rate fluctuations; *average variability* is defined as fetal heart rate fluctuations of 6-10 beats per minute. Because variability is due to the continuous interaction of the sympathetic and parasympathetic divisions of the autonomic nervous system, a decrease in variability indicates fetal distress.

Fetal Monitor vs. Fetoscope

It appears that fetal monitoring can tell us a great deal about the welfare of the fetus. But what about the obstetrician who counters with the statement, "No machine can equal the skill of a competent labor and delivery nurse, armed with a fetoscope?" In a study of 24,863 labors, the fetal heart rate was taken every fifteen minutes during periods in the first stage of labor, and every five minutes during the second stage or during any serious complications. However, only the most extreme cases of fetal distress were detected. Auscultation of the fetal heart rate proved to be a very unreliable indicator of fetal distress.[1] Furthermore, another source has stated that nurses relieved of "fetoscope duty" have more time to give emotional and physical comfort to their patients, that fetal monitoring need not be done at the expense of the comfort and well-being of the mother.[2]

Effect on Primary Cesarian Section Rate

There is some controversy as to whether fetal monitoring increases the primary cesarian section rate. One study indicates that monitoring resulted in a decrease in the number of cesarian sections necessary. Many deliveries which would have been performed by cesarian section because of auscultated fetal distress are managed conservatively because of the use of the more accurate electronic fetal monitor. The result was the delivery of healthy, non-depressed babies.[3]

A second source showed a decrease of about 75 percent in the primary section rate, with a resultant decrease in the number of depressed newborns.[4]

A four-year study in yet another setting indicated a definite rise in the number of primary cesarian sections, but there was a corresponding reduction in the perinatal mortality rate.[5]

According to Dr. Edward Hon, variable deceleration is the offending pattern in about 90 percent of fetuses who have been diagnosed as "in distress." In many hospitals, this "fetal distress" commonly contributes to the performance of a cesarian section. If patients were monitored, variable decelerations could probably be alleviated by maternal position change, which could prevent unnecessary cesarian sections.[6]

Although these sources show some disagreement as to the effect of fetal monitoring on the primary section rate, they do agree that overall, perinatal outcome is improved because of its use.





Interpretation of Recordings

Are the recordings difficult to interpret? Again, there is a difference of opinion. According to one author, although interpretation of abnormal fetal heart recordings may be difficult, a normal recording is decisive evidence in ruling out the possibility of fetal hypoxia.[7]

Other authors feel that fetal monitoring techniques are simple and convenient enough to be used routinely on an obstetric service, and that with little instruction there is minimal difficulty in recognizing a variety of fetal heart patterns and in being able to classify them as innocuous or ominous.[8]

Who Should Be Monitored?

Many authorities recognize that fetal monitoring is a necessity when the patient is classified as being of "high risk." One author found that late decelerations may persist for only thirty minutes before the fetus is severely compromised.[9]

What about the "low-risk" patient, the well-nourished, healthy, married twenty-two-year-old middle-class housewife who has had excellent prenatal care and is in labor at forty weeks' gestation? She is not a likely candidate for utero-placental insufficiency. However, cord compromise is estimated to occur in about one-third of all labors, according to blood gas and acid-base studies.[10]

In an obstetric service practicing fetal monitoring on all patients in labor, researchers found that fetal distress was detected earlier, and that because of the resulting remedial action, there was a marked decrease in the number of newborns with low Apgar scores.[11] In addition, a normal fetal heart rate pattern has been found to be almost completely accurate in predicting high Apgar scores.[12] (It should be noted here that the five minute Apgar score is a useful predictor of long-term neurologic impairment).[13] In 1972, Schifrin and Dame stated that not a single case of sudden unexpected fetal death has been documented on a monitored fetus.[14]

In another setting, deceleration patterns were seen in 52.8 percent of all monitored deliveries. One hundred and seventy eight of 749 patients showed cord complications during labor.[15]

One report compares the perinatal mortality rate in a large group of monitored patients with that of a larger, unmonitored group. Of 28,621 births, 6,923 were monitored, approximately 25 percent. For the most part, only high-risk patients were monitored. Ordinarily, this group would be expected to have a higher perinatal mortality rate. But in fact, the mortality rate in the monitored group was lower than in the low-risk, unmonitored group.[16]

In another hospital, only high-risk patients were monitored. The results were so favorable as far as reduction in perinatal deaths were concerned, that the service decided to use continuous fetal heart monitoring with all patients in labor.[17]

Cost vs. Value

Strong evidence from several sources suggests that total fetal monitoring (i.e. monitoring every fetus during labor) will halve the incidence of mental retardation and the yearly total of intrapartum deaths.[18] The cost of each monitor is about $6,000. It also costs to educate obstetric personnel in the interpretation of monitor recordings. The yearly increase needed to an already tightened hospital budget would, at first glance, make the concept of routine fetal monitoring, seem very impractical.

In an article published in 1975, Quilligan and Paul included a cost analysis that included the cost of equipment, supplies, and the training of personnel. The added cost per patient was estimated at approximately $35.50; on a nationwide scale in the United States, total fetal monitoring would cost $100 million per year. But it is estimated that by halving the incidence of mental retardation, savings to the taxpayer would be in the range of two billion dollars. It is also estimated that 6,000 intrapartum deaths would be prevented. Certainly these factors should be considered when cost of the monitors is being evaluated.

Weighing the Evidence

My review of the literature on continuous fetal monitoring has convinced me of many things:

- monitoring is not merely a fad;
- it does not necessarily depersonalize the nurse-patient relationship and may even enhance it;

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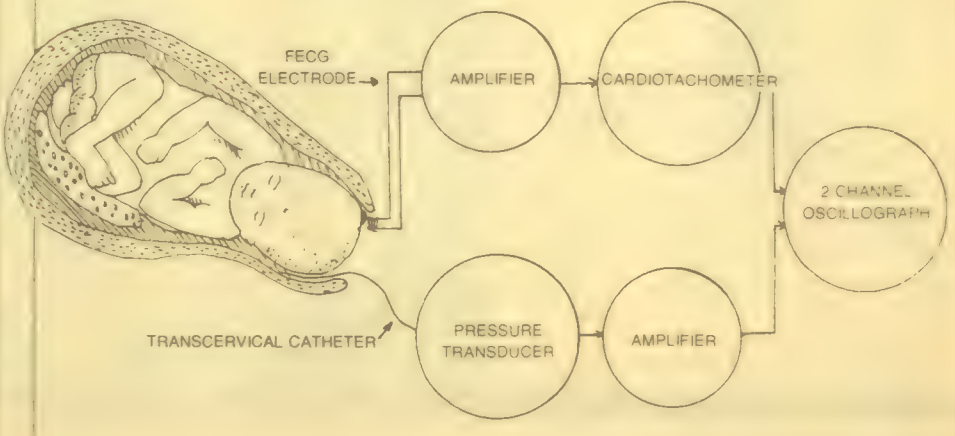
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An illustration of the indirect or external method of fetal monitoring. A tochodynamometer (at the top of the patient's abdomen) indicates the duration and frequency of uterine contractions. The transducer (lower on the patient's abdomen) indicates fetal heart rate.

- it is inexpensive in comparison to the long-term costs of caring for the mentally retarded and the savings in terms of human resources are incalculable;
- it may or may not increase the primary cesarian section rate but it does increase the chances for a favorable fetal outcome;
- interpretation of the recordings is a skill that can and should be learned by all obstetric personnel;
- monitoring is as important to the low-risk fetus as it is to the high-risk fetus — while the former may not be subject to chronic utero-placental insufficiency, he is still at risk from cord compression; there is currently no way to detect cord compression unless the fetus is monitored during labor.

One of my questions remains unanswered by the literature: why do we delay? Our perinatal mortality rate is a cause for concern in comparison with that of many other countries. our statistics for cerebral palsy and other intrapartum tragedies are appalling.

My reading convinces me that the evidence in favor of routine fetal monitoring is strong from medical, ethical, humane, and economic standpoints. The benefits to be reaped are considerable. Why are we in North America so slow to insure the welfare of our greatest resource, our unborn children?



Direct Fetal Monitoring

Ellen Hodnett *(B.S.N., Georgetown University, Washington, D.C.) is presently working as Lecturer with the University of Toronto Faculty of Nursing, teaching second and third year students in the undergraduate Baccalaureate program. Prior to 1975, Hodnett was Unit Administrator of the labor and delivery unit of North York General Hospital in Willowdale, Ontario.*

The other side of the uniform

Living with Adult Still's Disease

Being on the "receiving end" of medical and nursing care instead of the "providing end" can be a disconcerting experience for those of us who rarely assume the role of the patient. The author of "The Other Side of the Uniform," sheds some light on the frustrations and anxieties that accompany the unknowns of an illness such as Adult Still's Disease.

Yolanda Camiletti



Everything seemed to be happening to me all at once... I had just graduated from university with a B.Sc.N. and a B.A. in psychology, a new job in an Emergency ward was waiting for me and in one month I was going to be married. It was great the way things were working out. Although the past three months had been stressful, I was just now beginning to get accustomed to my new life style.

September rolled around and the hustle and bustle of the changing season was partly responsible for the streptococcal throat infection that I developed. Having had throat infections before, I thought nothing of it, and asked the doctor I was working with for an antibiotic. Ampicillin was prescribed. The next day, an itchy, pink rash developed on my arms and I felt flushed. Although I had taken Ampicillin as a child, it now seemed that I was allergic to it. Consequently, the Ampicillin was discontinued and replaced with Erythromycin.

Thinking that the adverse side effects of the Ampicillin would disappear, I was surprised that at the end of a week, my temperature was still elevated (38.5-39.5°C) and the pink, itchy, rash persisted becoming more evident at night. Another problem occurred as well — the fingertips of my right hand became very sore. I thought I might have injured them somewhere but I couldn't remember having done so.

The next day, the soreness started again but this time in my right wrist, and became increasingly severe so that by evening, I was in excruciating pain. My temperature continued to rise and the rash which now covered my whole body was in full "bloom." My husband took me to the emergency ward of the local hospital. An X ray of my wrist showed no abnormalities and it was diagnosed as "some type of tendonitis!" The physician told me that if it persisted, I should see my family doctor.

After a restless night's sleep, I woke up the next morning to find that my temperature was normal and that my rash had

Still's Disease, also known as juvenile rheumatoid arthritis, is a chronic systemic disease involving a wide spectrum of manifestations. All three forms of the disease — polyarticular, monoarticular, and acute febrile — have arthritis as a symptom but the pattern of joint involvement varies widely. In some cases, the systemic manifestations may be more obvious than the arthritis.

The etiology of the disease is unknown, but recent research suggests that some factor, for example, a viral or bacterial infection, triggers the normal inflammatory response. It may be related to collagen and autoimmune diseases. It occurs 2-3 times more frequently in females than males, usually before the onset of puberty.

The onset of the disease often becomes manifest after physical trauma to a joint or following an acute systemic infection. In its early stages, one or more joints may show signs of inflammation with stiffness, swelling, impaired range of motion and pain. The articular cartilage of the joints undergoes physiological change. Tendons, tendon sheaths, synovial tissue and muscle tissue may also be involved in inflammatory changes. Systemically, Still's Disease is characterized by severe fever (as high as 41° C), non-specific skin rashes, and enlargements of the liver, spleen, and lymph nodes. Anemia and cardiac involvement may also occur. The development of nodules is rare.

In children, the disease may cause irreversible eye damage due to scarring and adhesions. Certain skeletal abnormalities may occur due to interference with the normal rate of growth especially in the cervical spine.

Similar signs and symptoms occur in Lupus Erythmatosus and in allergic reactions to medication. It is important to rule out these diseases before making a diagnosis of Still's Disease.

disappeared. My good fortune did not last long however. By late afternoon, the fingers and wrist of my left hand were becoming sore. It seemed that the joints affected followed some kind of symmetrical pattern.

At this point I went to see my family physician. He felt that my symptoms were still due to my allergic reaction to the antibiotic and that after a couple of weeks, they would disappear. So I waited for two weeks.

Instead of getting better, however, I got worse. Every evening, my rash would emerge in pink-red blotches and streaks. Some areas of the rash were elevated, others weren't. There seemed to be no particular pattern to it and any area of my body that was scratched left a rash. The unique appearance of the rash, unfortunately, did not help the doctors in their diagnosis.

I found that my fever was always elevated in the evenings. More and more joints became involved, among them, my knees, shoulders, jaw and ankles. They began to swell and became reddened and hot to touch. The pain was very severe and at times would leave me immobile.

One month after the onset of this illness, there was still no concrete evidence to support a specific diagnosis. So my family doctor referred me to a rheumatologist. Every possible blood test was done but they revealed little. The results showed that I had an elevated erythrocyte sedimentation rate, elevated white blood cell count and a decreased hemoglobin. Tests for Lupus Erythmatosus and the Rheumatoid Factor were both negative.

During the physical examination the rheumatologist found that my spleen was enlarged. He also noted that I had a second grade systolic heart murmur. Xrays all came back negative.

One morning, a little more than five weeks after the beginning of this "conundrum" (as my physician referred to it), I was unable to move. My body was stiff and it caused me considerable pain to make the slightest movement. My doctors felt that I should be admitted to hospital.

There were many feelings racing through my mind at this time. I had not reached the "why me" stage of my illness but, instead, was in the "self-centered" here and now. I had pain and I wanted relief from this physical condition which was causing me discomfort and many psychological conflicts.

For a long time, I had no certain or fixed diagnosis. This produced feelings of anxiety and fear. How would the doctors be able to treat me if they didn't know what to treat? Why didn't they know what to treat? Out of the millions of people in the world, could I be the only one with these symptoms?

In hospital, it was strange to be on the other side of the uniform. I felt helpless, as though I had lost all strength and vigor. In familiar surroundings, where once I had been bouncing with energy, helping the sick by being "useful," I was now in the role of the "sick patient." The tables were turned and it was all the more difficult for me to accept my illness. Even the hospital bed with its side rails which should make a patient feel secure did just the opposite for me. It made me feel caged in, and very separate from my husband at a time when I really wanted to be close to someone.

There were many physiological, psychological and emotional problems that I had to deal with during my illness. Some of my feelings changed with time and reflection; others because I was able to talk them over with medical staff or with my family.

That first evening in hospital, I was given a number of different kinds of medication. Unfortunately, I was allergic to one of the drugs and developed a reaction to it. My eyes played tricks on me, nothing seemed to be in the right perspective, everything was hazy. I felt nauseated and my body was covered with a red rash. My confidence in the doctors was dwindling rapidly. Fortunately, my husband was able to stay with me until two o'clock that morning. However, by morning, instead of being better, I was worse, both physically and mentally. I felt like signing myself out of the hospital and going home. It seemed as though nobody was able to help me and that I was considered by the medical staff to be just a "specimen" with a rare illness.

To add to my frustration, at about nine-thirty that morning, two teams of medical students were given the opportunity to 'view' my unusual rash. Although I realize that experience is the best teacher, I resented having ten student doctors examine my skin by checking for blanching and elevated areas. Besides feeling like the star of a 'freak show,' I was extremely uncomfortable since I was in pain. All this led me to an increasingly negative attitude towards my illness.

Late that same afternoon, I was transferred to a medical floor where I spent the rest of my hospitalization. My memories of the first five days in this room are still obscure. I can remember the pain, nurses helping me to the bathroom, eating and sleeping. With my physical needs met, I had no interest in anything else. Although I was indifferent to his presence, my husband sat with me every day while I would either cry or sleep.

By the sixth day, I had become more aware of my surroundings. Out of curiosity, fear and the hope of finding a cure for my illness, I questioned doctors and nurses on almost everything they did. I would get very angry when I received the wrong X ray, a double dosage of Prednisone or when the nurse caring for me had no idea of what my illness entailed.

After several weeks of physical examinations, laboratory testing and careful observation of my signs and symptoms, a diagnosis of Adult Still's Disease was finally made. According to my rheumatologist, my treatment would consist of rest, medication

Living with Adult Still's Disease



and time. There was no instantaneous cure and since the cause is unknown, my doctor was only able to treat the symptoms. The drug of choice at this time was Prednisone 60 mg per day.

It was not long after this that I was discharged from hospital and returned home. It was necessary to carry on with the medical regime and to begin to undertake normal daily chores. It was also important for me to realize my own physical limitations since almost every joint in my body was affected by the inflammatory process. Because of this, I had to be careful not to place too great a strain on my joints or to exercise them too strenuously. If a joint became reddened and sore one-half hour after exercising, then I had gone beyond my limitation.

By the first week of December, three weeks after the onset of symptoms, I was sure that I was getting better. I could walk well, my joints caused me only minor discomfort and my Prednisone level which the doctor had decreased by 5mg per week, was down to 5 mg every second day.

However, two weeks later, my temperature became elevated each night, my rash returned, my fingers were reddened and swollen and my other joints were sore. Again it was necessary for me to go into hospital during this exacerbation period. Prednisone 70 mg per day was prescribed. I remained in hospital until all the symptoms had stabilized.

It is now many months since my last discharge from hospital. I am still taking Prednisone and continue to experience mild joint pain. I must still watch out for activities that might put too great a strain on my joints but I am able to do most things for myself. The side effects of the Prednisone such as moon face, fat deposits, weight gain and an elephant hump at the back of my neck are still apparent although subsiding.

To conclude, I would like to stress some major points about Still's Disease:

- The disease itself has many unknowns. What we do know is that this illness is not the debilitating type of arthritis.
- Steroids do not cure the illness but serve only to alleviate the symptoms. It is important for the nurse and patient to realize the many side effects caused by this medication and to understand the physiological and psychological effects the drug may produce.
- Due to the drug therapy which causes the suppression of symptoms, there is no method of detecting the different stages of the disease.
- Steroid levels must be decreased very slowly. A rapid decrease may cause an exacerbation of symptoms.

Tips for patients with Still's Disease

- Relaxation — rest for 8 to 12 hours per day.
- Avoid stressful situations, if possible.
- Know your own limitations. Only you know how much you can do. Physical exercise is important to maintain joint mobility, but set your own pace.
- Take medication as prescribed.
- When joints become stiff and swollen, the best therapy is rest. An ice pack or hot compress, whichever feels most comfortable, may help.
- Although the joints may not be visibly swollen, they may be sore.
- Use self-help devices e.g. sit on a stool to do dishes, allow dishes to dry themselves, use electrical appliances such as a can opener.
- Remember, healing takes time. Never give up. Start out slowly then progress.

Yolanda Camiletti, *(R.N., B.A.), author of* The Other Side of the Uniform, *worked for three months in an Emergency Department before the onset of her illness. After six months of ill health, she began the search for a new position. She states," Looking for work was a very frustrating experience. The general questions asked by employers were:*

1. When do you think you will have another flare-up?

2. Oh, you are still on medication?

3. Do you think you can stand for 12 hours of the day?

After another six months of searching for a position, I found an understanding exmployer at the Middlesex-London District Health Unit.

At the time I started working with the health unit, I did have another exacerbation of symptoms. With the early recognition of symptoms, and prompt medical care, my recovery rate is progressing at a much faster pace than during the previous relapses. I was kept mobile and out of the hospital. I was also able to hold my position at the health unit.

At this point, only time will reveal the course of my illness. It is my greatest hope that some day, someone, interested in researching this disease will discover the exact cause of the illness and perhaps even the cure."

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By **Gretchen Mayo Reed,** BS, MA (Ed), MA (Bio), Univ. of Tennessee Center for the Health Sciences, and the late **Vincent F. Sheppard,** MEd, PhD. About 350 pp. Illustd. Soft cover. About $8.25. Ready March 1977.
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Geared to the needs of student nurses, this text presents the same concepts and principles as in **Guyton's Textbook of Medical Physiology,** but it omits most of the references to research work, many of the qualifying explanations, and some of the references to clinical problems. Up-dated throughout, the sections on the kidneys, the nervous system, and endocrines in particular have been thoroughly reworked.

By **Arthur C. Guyton,** MD, Univ. of Mississippi School of Medicine, Jackson. About 930 pp., 420 ill. About $17.00. Just Ready. **Order #4383-3.**

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By **Keith F. Moore,** MSc, PhD, FIAC, Prof. and Chairman, Dept. of Anatomy, Univ. of Toronto, Faculty of Medicine. About 430 pp., 360 ill. Ready March 1977. **Order #6471-7.**

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By **Gloria Leifer,** RN, MA, formerly of Hunter College of CUNY. About 350 pp., 195 ill. About $10.05. Ready March 1977. **Order #5713-3.**

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By **Dee Ann Gillies,** RN, EdD, the Dept. of Education, Heart and Hospitals Governing Commission of Cook County, Chicago; and **Irene B. Alyn,** RN, PhD, Univ. of Illinois College of Nursing, Chicago. 236 pp. Illustd. $9.80. April 1976. **Order #4133-4.**

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By **Joan Luckmann,** RN, BS, MA; and **Karen Creason Sorensen,** RN, BS, MN. 1634 pp. 422 ill. $21.35. Sept. 1974. **Order #5805-9.**

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Names and Faces

Shirley Alcoe (B.A.; B.Ed.; M.A.; M.Ed.; Ed. D.) Associate Professor, Faculty of Nursing, University of New Brunswick, is the new Chairman of the Canadian Tuberculosis and Respiratory Disease Association Nurses' Section. She has previously worked as a staff nurse in Port Colborne, Ontario, Edmonton and Ottawa and in public health in New Brunswick. In 1965, she joined the World Health Organization and went to India to assist national nursing groups to provide short courses for nurses. Later she advised Bombay University on Nursing Curriculum.

Alcoe has worked on planning committees for the New Brunswick TB and RD Association and has published several papers on health and physical education for students.



Val Cloarec, executive director of the Saskatchewan Registered Nurses' Association since 1974, has resigned effective March 4, 1977, and has accepted the position of Director of Vital Statistics, Department of Health, Regina, Saskatchewan.

Cloarec is a native of Saskatchewan and since her graduation from Holy Cross Hospital School of Nursing in Calgary, has spent most of her time in the nursing field. She has worked as a staff nurse in hospitals in Saskatchewan and in the Northwest Territories, as well as having worked for the Department of Public Health as a staff nurse, regional nursing supervisor and nursing consultant.



Nicole Fontaine has been appointed Director of Public Relations Services for the Canadian Nurses Association. A journalist, broadcaster and consultant, she has served, since 1970, in various capacities with the Secretary of State, Health and Welfare's Fitness and Amateur Sports Directorate, Federal-Provincial Welfare conferences, and more recently the Official Languages Branch and Communications Division of the Treasury Board.

A graduate of the University of Ottawa, her experience includes working for the French Government in Rabat (Morocco), newspapers in Paris, Ottawa and Montreal, Expo '67, advertising and town planning firms in Quebec, Radio-Canada in Vancouver and the 1970 British Commonwealth Games, at Edinburgh.

Marilyn D. Willman has been appointed director of the School of Nursing, University of British Columbia effective July 1, 1977. Willman, president of the state-wide University of Texas System School of Nursing, earned her B.Sc.N. from the University of Michigan in 1952. After working as a staff nurse and clinical instructor for six years, she enrolled at the University of Texas where she received her master's degree specializing in administration in nursing education and her doctorate in educational psychology. She joined the faculty of the University of Texas in 1961.

Willman succeeds **Muriel Uprichard,** head of nursing at U.B.C. since 1971, who has been an outspoken critic of what she termed the "hand-maiden servant" role assigned to nurses in many hospitals. She retires June 30, 1977.

The Canadian Council of Cardiovascular Nurses has announced its board of management for 1977. Members of the Executive Committee are:
Chairman: **Carolyn Stockwell,** Windsor, Ont.;
Past Chairman: **Joan Breakey,** Toronto, Ont.;
Vice-Chairman: **Cecile Boisvert,** Montreal, Que.;
Recording Secretary: **Therese Poupart,** Boucherville, Que.;
Treasurer: **Jane Wilson,** Toronto, Ont.;
Membership Secretary: **Madeleine McNeil,** Dartmouth, N.S.;
Provincial representatives are:
Alberta: **Kathryn Bradley,** Edmonton;
British Columbia: **Judith Shields,** New Westminster;
Manitoba: **Gina Taam,** Winnipeg;
New Brunswick: **Helene Roy,** Bathurst;
Nova Scotia: **Anna Freeman,** Halifax;
Newfoundland: **Glenys A. Whelan,** St. John's;
Ontario: **Isabelle Kemp,** Sudbury;
Prince Edward Island: **Barbara Baglole,** Charlottetown;
Quebec: **Francine Beauchamp,** Montreal;
Saskatchewan: **Toni Beerling,** Saskatoon.
Registered nurses interested in cardiovascular health care are invited to join the C.C.C.N. Write: *Canadian Heart Foundation, Suite 1200, One Nicholas St., Ottawa, K1N TB7.*

Rachel Palmer of Bunjul, Gambia has been elected President of the Commonwealth Nurses Federation. Forty national nurses' associations of Commonwealth countries are now members of the Federation.

Leona Margaret Bowes has been honored by the University of Saskatchewan as the most distinguished graduate in nursing at the fall convocation.

New Appointments

Sandra A. E. Rencz. (R.N. Kingston General Hospital, Kingston, Ontario; B.N., McGill University) has been appointed lecturer in nursing at The University of New Brunswick, Fredericton. Her primary responsibilities at U.N.B. will be clinical teaching in the nursery area, pediatrics and obstetrics.

Faye Birt has recently joined the staff of the Prince Edward Island Nurses' Provincial Collective Bargaining Committee as an Employment Relations Officer. Faye, a graduate of the Prince Edward Island School of Nursing, was employed by the Prince Edward Island Hospital, Charlottetown, P.E.I., and served as President of their Staff Association.



Patricia A. Phillips (R.N., Vancouver General Hospital; B.Sc.N., University of Alberta) has been appointed MEDICO project director of a 14-member CARE/MEDICO team that conducts training programs for physicians, nurses and laboratory technologists. Based in Sarakarta (Solo), Indonesia, she will also coordinate a newly planned community health program which will extend into rural areas.

Phillips has had extensive overseas nursing experience having worked in South Africa and with CUSO in India and Bangladesh in mother-child health centers and family planning projects.

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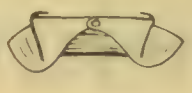
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Calendar

March

Issues in Community Health to be held March 28-April 1, 1977 at the Academy of Medicine, Toronto. Public Health Nurses and those interested in community health issues invited. Contact: *Grace Batchelor, Coordinator of Continuing Education, Division of Community Health, Room 124, Fitzgerald Building, University of Toronto, Toronto, Ont., M5S IAI.*

Nursing and the Law — a one-day seminar for nurses and allied health professionals to be held on March 19, 1977 at the University of New Brunswick, Fredericton, New Brunswick. Guest lecturer — Mr. Lorne Rozovsky. Contact: *Carole Estabrooks, President, Nursing Society, Faculty of Nursing, University of New Brunswick, Fredericton, New Brunswick, E3B 5A3.*

Foundations of Hospital Management — A three-day program for managers from all hospital departments. To be held in Montreal on March 16-18, 1977 and in Toronto on March 23-25, 1977. Tuition: $120. Contact: R.M. Brown Consultants 1115-1701 Kilborn Ave., Ottawa, Ont. K1H 6M8.

The Executive Nurse — A three-day program for nurses in management positions. To be held in Vancouver on March 9-11,1977, and in Toronto on April 20-22, 1977.Tuition $120. Contact: *R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ont., K1H 6M8.*

Workshop in Psychodrama at the Clarke Institute of Psychiatry, Toronto on March 17-18, 1977. Contact: *Dorothy Brooks, Chairman, Continuing Education Program, 50 St. George St., Toronto, Ont. M5S IAI.*

The Management of Motivation — A two-day program for all health services managers. To be presented in Montreal on March 14-15, 1977. Tuition: $100. Contact: *R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ont. K1H 6M8.*

Annual Meeting of the Canadian Nurses Association, 31 March 1977, Ottawa. Contact: *The Canadian Nurses Association, 50 The Driveway, Ottawa, Ont., K2P 1E2.*

April

The Grieving Process and the Dying Process at the University of Toronto on Wednesday evenings April 6 - May 25, 1977. Contact: *Dorothy Brooks, Chairman, Continuing Education Program, 50 St. George St., Toronto, Ont. M5S IAI.*

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First International Congress on Toxicology to be held March 30 - April 2, 1977 in Toronto, Ontario. Contact: *Dr. Robert G. Burford, Secretary, ICT, c/o G.D. Searle & Co. of Canada Ltd., 400 Iroquois Shore Road, Oakville, Ontario. L6H 1M5.*

May

Intensive Care Symposium. Lectures in Cardiology, Neurology, Respiratory Problems, and Hyperalimentation. To be held at Selkirk College, Castlegar, B.C., on May 28-29, 1977. Contact: *Ms. Sandra Rubin, Kootenay Lake District Hospital, 3 View St., Nelson, B.C.*

Oncology Nursing Society Second Annual Convention to be held in Denver, Colorado on May 15-16, 1977. Contact: *Ms. Daryl Maass, Secretary, Oncology Nursing Society, N.Y.U. Medical Center, 560 First Ave., New York, N.Y. 10016.*

Getting Through to People — A two-day workshop to improve communication skills. To be held in Toronto on May 9-10, 1977. Tuition: $120. Contact: *R.M. Brown Consultants,1115-1701 Kilborn Ave., Ottawa, Ont. K1H 6M8.*

The Educator-Manager — A three-day program for directors, coordinators and instructors in staff development and inservice education departments, to be held in Toronto on May 11-13, 1977. Tuition:$120. Contact: *R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa.*

Intensive and Rehabilitative Respiratory Care presented by the Pulmonary Division of the University of Colorado Medical Center, Denver, Colorado, May 23-27, 1977. Fee: $150. Contact: *American College of Chest Physicians, 911 Busse Highway, Park Ridge IL, 60068.*

Association for the Care of Children in Hospitals Annual Conference, "Speaking Out for Children," in Dearborn, Mich., May 25-28, 1977. Contact: *Mary F. Podolak, R.N., Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, Michigan 48201.*

Books

Nursing Care of the Patient with Burns by Florence Jacoby. (2ed.) St. Louis, C.V. Mosby, 1976.
Approximate price $7.30.
Reviewed by Mary Shields, R.N., B.Sc.N., Clinical Instructor, School of Nursing, University of Alberta Hospital.

A book devoted to nursing care of a patient with burns is very rare and consequently the new edition of Florence Jacoby's text was most welcome.

As in the first edition, Jacoby covers general topics such as the incidence of burns, and the history of burn treatment. She also discusses specifics in anatomy, pathophysiology, nutrition, complications, and related nursing care.

The book is written in an easy-flowing style, but is very detailed in topic coverage in its 175 pages.

I was pleased to see two new chapters included in the second edition. One of these deals with the volume and composition of fluid therapy. This chapter opens up the controversy concerning what kind of fluid and how much of it is to be given to burned individuals during the acute phase of their illness.

The second new chapter is called a 'Teaching Appendix.' It is divided into theoretical and clinical objectives, with review topics and content clearly and concisely listed. As is stated; "They can be adapted to fit undergraduate, graduate, in-service, and continuing education programs.'

In the remainder of the book, I discovered a very thorough updating of all topics. Where relatively new advances have been made, (for example in topical antibiotics and debriding enzymes) Jacoby has thoroughly covered the pathophysiological and nursing implications of these advances Statistical references and bibliographies have been extended and updated.

I would have no hesitation in recommending this text to any nurse who is interested in helping to further the care of a burned patient.

Discussing Death: A Guide to Death Education by Gretchen C. Mills, Raymond Reisler, Jr., Alice E. Robinson and Gretchen Vermilye, 140 pages, Illinois, ETC Publications, 1976.
Approximate price: $5.50
Reviewed by Larry Schruder, Instructor, Social Sciences, Algonquin College Nursing Program, Lorrain Centre, Pembroke, Ontario.

Social scientists, nursing educators, teachers and the public are becoming progressively more aware of the alarming paucity of information that humans possess regarding the topic of death, and the lack of awareness of their own feelings and attitudes about it. *Discussing Death* starts from this realization and does an admirable job at suggesting ways and means of correcting this situation. It joins a very small, select group of publications that centers on techniques for educating on the topic of death.

The authors have presented their information in a style that is written primarily for teachers. It is a resource book dealing with many aspects of the topic of death, but it is not structured as a death education course. The guide is separated into four age levels: 5-6 years, 7-9 years, 10-12 years, and 13-18 years, and presents material and experiences that would be most relevant at each level. The comments at the beginning of each age unit briefly summarize the typical conception of death held by the child at this developmental level. Each learning experience is organized into Opportunity, Objectives, Activities and Notes to Teacher. Complete bibliographical information follows each of the four age levels. Within each age unit, the learning experiences are presented in a somewhat sequential fashion from the basic to the more difficult concepts.

The material dealing with the elementary school-age child occupies approximately one-half of the book and provides refreshing avenues for introducing the topic of death to this group. It has an excellent focus on feelings and would be a tremendous resource for an innovative elementary school teacher or a concerned parent.

The remainder of the book examines techniques and themes for use with young adolescents. Although the feeling, experiential, and awareness measures are still incorporated, there is a greater inclusion of factual or informational material on the topic of death. Literary themes are used to direct the discussion of death issues. I had some difficulty with such a strong literary emphasis, although an appendix section gives the wary (such as myself), some pointers on its efficient use.

As an instructor in Death Education courses, I found this publication refreshing, with some innovative techniques and resources. I particularly enjoyed the feeling-centered approach of many of the ideas because I see this as being a crucial element of any death education endeavor. Although it is primarily geared for the elementary and secondary level, *Discussing Death* (with some selection and modification) would enrich any instructional work on the topic of death in the health and nursing area. It could serve as a valuable resource to those who see a need to educate in this area, but who question their courage, insight or ideas to implement a constructive program on their own.

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Library Update

Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

1. Archer, Sarah, Ellen. *Community health nursing; patterns and practice,* by...and Ruth Fleshman. North Scituate, Ma., Duxbury Pr., c1975. 441p.
2. Association of Registered Nurses of Newfoundland. *Annual meeting programme and folio of reports 1976.* St. John's, 1976. 112p.
3. Auerbach, Stevanne. *Child care: a comprehensive guide,* edited by...with James A. Rivaldo. New York, Human Sciences Press, c1976. 2v.
4. Canadian Council on Hospital Accreditation. *Guide to hospital accreditation.* Toronto, 1977. 128p.
5. Canadian Council on Social Development. *Community multi-service centres; summary of recent developments in the delivery of personal health and social services and report of meeting on community multi-service centres, Vancouver 1976.* Ottawa, c1976. 127p.
6. Canadian Heart Foundation. *Heart: facts & figures.* Ottawa, 1976. 12p.
7. *Care for the injured child,* by the Surgical Staff, the Hospital for Sick Children, Toronto. Baltimore, Md., Williams and Wilkins, c1975. 444p.
8. Carter, Novia. *Evaluating social development programs,* by...with Brian Wharf. Ottawa, Canadian Council on Social Development, 1973. 161p.
9. *Citizen evaluation of mental health services: a guidebook for accountability,* by Val. D. MacMurray... et al. New York, Human Sciences Press, c1976. 124p.
10. Le Conseil canadien de Développement social. *Les centres communautaires de services polyvalents; résumé des développements récents de la prestation de services sociaux, sanitaires, personnels et rapport sur la réunion relative aux centres communautaires de services polyvalents, Vancouver 1976.* Ottawa, c1976. 146p.
11. *Ethics and health policy,* edited by Robert M. Veatch and Roy Branson. Cambridge, Ma., Ballinger, c1976. 332p.
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13. Morris, Terry. *The story of MEDICO; a service of CARE.* Baltimore, Md., Waverley Press, 1976. 62p.
14. National League for Nursing. Council of Baccalaureate and Higher Degree Programs. *Accountability and the open curriculum in baccalaureate nursing education.* Papers presented at a Workshop...in February 1976 at Denver, Colorado, New York, 1976. 48p. (NLN Publication no. 15-1628)
15.—. Dept. of Baccalaureate and Higher Degree Programs. *Curriculum in graduate education in nursing: Pt. 2. Components in the curriculum development process.* New York, 1976. 64p. (NLN Publication No. 15-1632)
16. O'Bryan, K.G. *Les langues non officielles; études sur le multiculturalisme au Canada,* par...J.G. Reitz and O.M. Kuplowska. Ottawa, Ministre des Approvisionnements et Services Canada, c1976. 294p.
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18. Organization for Economic Co-operation and Development. *Reviews of national policies for education: Canada.* Paris, 1976. 264p.
19. Organisation mondiale de la Santé. *Matériel de référence destiné aux auxiliaires sanitaires et à leurs enseignants.* Genève, 1976. 97p. (OMS Publication Offset no. 28)
20. Padilla, Geraldine V. *Interacting with dying patients; an inter-hospital nursing research and nursing education project,* by... Veronica E. Baker and Vikki A. Dolan. Duarte, Ca., City of Hope National Medical Center, 1975. 219p.
21. Roche, Douglas. *Justice not charity; a new global ethic for Canada.* Toronto, McClelland and Stewart, c1976. 127p.
22. *Les toxicomanies autres que l'alcoolisme.* Guide de diagnostic et de traitement, éd. 4, revue et mise à jour. Montréal, Corporation professionnelle des médecins du Québec, 1976. 54p.
23. Victorian Order of Nurses for Canada. *Report 1975.* Ottawa, 1976. 80p.
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25. Association canadienne contre la tuberculose et les maladies respiratoires. *Rapport 1975/76.* Ottawa, 1976. 14p.
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Government documents

Canada

32. Advisory Council on the Status of Women. *Birth planning.* Ottawa, 1976. 16p. (The Person Papers series no. 4)

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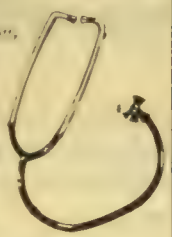
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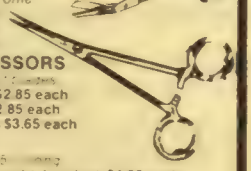
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34.—. *Regarding rape.* Ottawa, 1976. 16p. (The Person Papers series no. 2)
35. Bibliothèque nationale du Canada. *Rapport annuel du directeur général, 1975/76.* Ottawa, Ministre des Approvisionnements et Services Canada, 1976. 61p.
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43. Statistique Canada. *La statistique hospitalière. Vol. 1. Lits, services, personnel, 1973.* Ottawa, 1976. 142p. **R**
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46. Council of Health. Committee on Professional Licensure. *Report.* Halifax, 1976. 69p.

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47. Ministry of Health. *The clinical specialists in psychiatric and community mental health nursing in Ontario.* Toronto, 1976. 12p.
48. Ministry of Labour. Research Branch. *O.H.I.P., major medical, prescription and dental plans in Ontario collective agreements.* Toronto, 1976. 15p. (Bargaining information series, no. 16)
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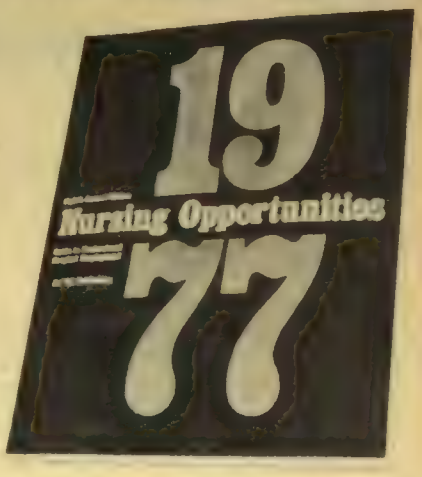
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55. Cunningham, Rosella. *An analysis of the application of the concept family-centered care in public health nursing visits.* Toronto, Faculty of Nursing, University of Toronto, 1976. 68p. **R**
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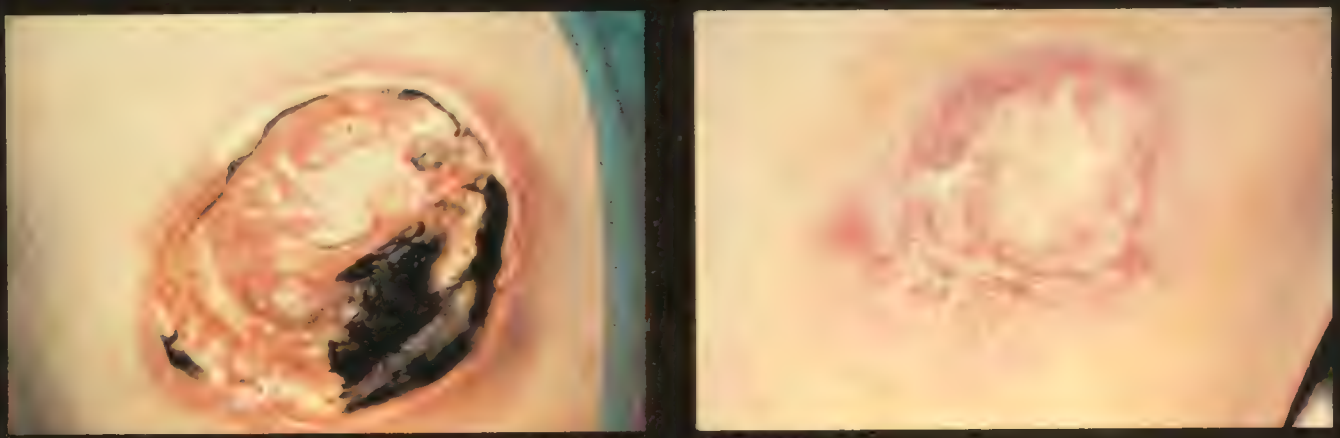
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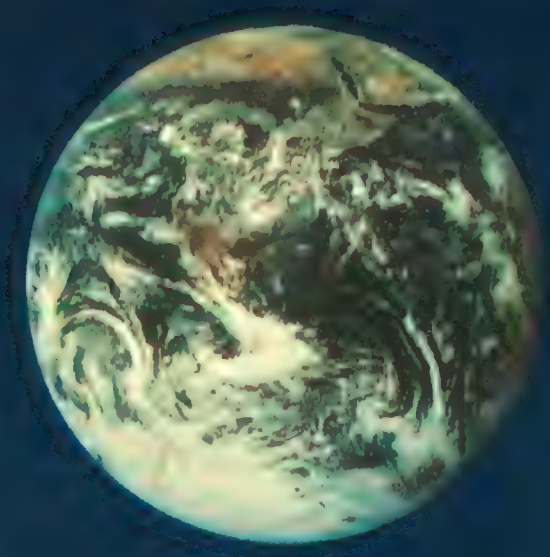
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the canadian nurse

April, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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The cover photo for this month's theme issue, "The Seventh Age — Caring Makes the Difference," was made available through the Canadian Council on Social Development.

Photos for the theme montage on page 23 are courtesy of Information Canada Phototheque, Health and Welfare Canada and Canadian Council on Social Development.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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Perspective



Janet C. Kerr, associate professor in the Faculty of Nursing, the University of Calgary, is probably best known to Canadian nurses as the co-author with Shirley R. Good, of "Contemporary Issues in Canadian Law for Nurses."

She holds a Specialist in Aging Certificate in Public Health from the Institute of Gerontology, the University of Michigan/Wayne State University, and has presented several papers on gerontological/geriatric nursing to groups that include the Canadian Association of University Schools of Nursing, Public Health Nursing Supervisors in the Province of Alberta and nursing staff of institutions in that province.

She has served on a variety of committees of professional associations, including the Alberta Association of Registered Nurses, Alberta Public Health Association, Canadian Nurses Association Testing Service and Canadian Association of University Schools of Nursing.

Guest editorial

The issues in geriatric/gerontological nursing are not difficult to find; the scope and variety of articles in this month's journal attest to this fact. Nevertheless, how many practicing nurses make a point of becoming informed in this very significant area of nursing practice? How many are even interested? How many students enrolled in schools of nursing across the nation have the opportunity to experience a curriculum sequence designed to assist them to learn to nurse elderly people?

Negative stereotyping of the elderly permeates our society, and nurses are by no means immune to social values and conventions resulting from this phenomenon. Unfortunately caring for the elderly is commonly viewed in nursing as less interesting, less challenging and less satisfying than caring for persons in other age groups. Nothing could be further from the truth! Analysis of health service requirements for various age groups indicates that the elderly require a substantial proportion of available nursing services in both community health nursing and hospital nursing practice. It is likely that in the future nurses will be spending even more of their time engaged in geriatric nursing.

The population of the institutionalized aged is often overestimated — possibly because of the high visibility of institutions and possibly because we tend to think of aging in terms of illness, disease or death rather than a natural biological, psychological and sociological process that shows great variation from one individual to another. Currently the former represents only a little more than seven percent of those over 65 years of age.

Caring for the sick is an important social responsibility and we have provided facilities for this in Canada to the extent that we now have one of the highest institutional bed ratios for persons over 65 years of age of any country in the world, according to the World Health Organization Expert Committee on Planning and Organization of Geriatric Services.

Even so, we staff the institutions that provide geriatric care for the most part with non-professionals. Here we have the sick elderly receiving nursing care which is rendered in large part by untrained individuals. It is obviously not a case of insufficient professional nurses, but, rather, of not valuing the standard of care which can only be provided by professionally prepared nurses.

It has been suggested that for every aged person in an institution, there are two comparable aged persons who are housebound and who refuse to go the route of the institution. Certainly the elderly individual entering an institution is likely to lose his network of social relationships based in the community and thereby lessen his capabilities for independent living. For this reason, there is a great need for more emphasis upon prevention of illness through the development of viable alternatives to institutionalization in the form of strong community supportive services for the elderly.

The philosophy of health care that prevails in society finds its implementation in the financial arrangements which make it possible for people to receive that care. If these arrangements do not make provision for community health and social services to enable people to stay well and remain in their own homes and familiar environments, then it would seem that our society does not value these ends to the extent that we may feel is desirable. We need to develop more than token home care programs, homemaker and handyman services, day hospital and day care centers, and so on to enable senior citizens to remain with their families and in their own homes if they so desire for as long as they wish.

Finally, what is the responsibility of community health nursing agencies for meeting the health needs of elderly citizens? While the voluntary agencies have been highly involved in the provision of health care to senior citizens for a number of years, the official health agencies have historically been preoccupied with the needs of mothers and children. Although there is now a beginning awareness of the need for change and some visible evidence of it, there needs to be considerably more concrete action in this sphere. Community health nursing has an important and vital contribution to make to senior citizens living independently and most certainly there is an urgent and important need for this service.

Indeed, practitioners in every area of nursing can exert a potentially positive influence on the improvement of geriatric health care services by keeping abreast of the new knowledge in this field, by becoming more sensitive to the individual and collective needs of the elderly and by standing up and being counted on the issues!

— Janet C. Kerr

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To our readers:

It has been brought to our attention that the February issue of *The Canadian Nurse* contained a classified advertisement that contravened our policy of accepting for publication only those ads which cannot be considered discriminatory under the Human Rights Code.

We do our utmost to prevent this type of unfortunate occurrence. In this case, our utmost was not good enough.

We apologize to all of our readers who found the ad as offensive as we did when it was drawn to our attention.

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Input

Declining standards of care

During the past year nursing staff in this province as indeed in most other provinces has been greatly reduced. This situation has caused much concern as on several occasions it has literally forced us to run — not for the sake of fire or hemorrhage — but in order to keep up with workload.

I could give many examples of situations which were potentially hazardous although, so far, not fatal. However, the last straw, a comparatively trivial incident, came when a patient complained that although told to drink he had not been supplied with any fresh water for sixteen hours!

The fact that I had been busy giving an hourly heparin I.V. and concentrated care to two of my six patients (on one occasion I had had ten patients) pushing one patient to emergency etc. did not impress him.

As a urological patient he felt and indeed I agreed with him that service should have been better. Also, since he was the fittest of my patients it was after my tour of duty ended that I was able to make his bed.

Arriving home that evening I was exhausted, frustrated and angry. Although I had worked hard and finally got everything done, the reason I hadn't done my nursing duties at the right time was because I was portering patients and running to the diet kitchen for their lunch etc. This made me decide to write to my members of parliament in an effort to improve the situation.

I enclose a copy of the letter addressed to the Hon. R.H. McClelland (B.C. Minister of Health) for your perusal.

Dear Sir:

Recently a patient under my care complained that never in his life had he received such poor service! Unfortunately his complaint was justified! NOT because the Nurse was neglecting her duties. NOT because the Nurse was at coffee break but simply because the Nurse (as indeed the rest of the staff) had too heavy a workload and too few hands.

A Registered Nurse with many years of experience in all areas of nursing, I am used to pressure and accustomed to hard work. Nevertheless, I am tired that in order to maintain high standards of care I must give up my coffee breaks and go off duty thirty to forty-five minutes late on an almost regular daily basis. The sad part is that a high percentage of a nurse's time is spent in non-nursing duties! A mechanic does not change tires, a chef does not wash pots. Why should a Nurse spend her time running messages and specimens to the lab, or portering patients to other departments?

If, sir, the government is determined to run a hospital on a strict budget with a skeleton staff, then, sir, the public is entitled to be made fully aware of the reasons for this intolerable situation which does indeed sometimes cause poor service. Pamphlets should be published and placed in each patient's drawer (if not pamphlets at least display large notices) advising them and their relatives of the fact that there has been a great reduction in staff numbers resulting in extra nursing and non-nursing duties, which makes it almost impossible to give care to every patient at the *right* time. Naturally it is the patient who is the least ill who receives less attention. Though sometimes their psychological needs are greater!

Perhaps instead of determining size of staff by statistics and work efficiency experts the government should employ a Registered Nurse Consultant who actually spends three to six months at a time in busy areas not discussing, not looking, not evaluating or supervising (for as Sir Winston Churchill once said anyone can criticize not everyone can do!) but actually working all three shifts on a full-time basis. And who knows, when one of the efficiency experts experiences the frustration, exhaustion and heartache associated with modern day nursing maybe the human element might once again become the greatest part of nursing.

If all the hours of unpaid overtime each nurse had done within the past year were added together, we must have saved the government thousands of dollars.

I beg of you to take some constructive measures to aid your fellow man, for who knows perhaps you or your loved ones might find yourselves without help because one nurse is too busy pushing a patient to another department and the other nurse is too busy answering the telephone which sometimes rings incessantly, or answering half a dozen call bells which somehow all go on at once...

I would be pleased to discuss this increasingly intolerable situation, both for the patients' safety and the staff's sake with you and your ministers.

— Thelma Elizabeth Miller, R.N., Surrey, B.C.

Reducing patient anxiety

I am writing to express my appreciation for publishing "Nursing the Acutely Psychotic Patient," (February). I work in a Psychiatric Hospital myself and found this article very helpful as I often feel we don't use the necessary measures to reduce patients, anxiety in their psychotic state.

Hope to see more articles in the future regarding the psychiatric patient.

— Marjorie Newton, Reg. N., Scarborough, Ont.

Salutations!

Dear Hanna: To avoid any possible confusion, lest someone share this nominal identity with me, I hereby declare myself Dann No. 1. If, however you feel this too "à la 1984" you could refer to me as Mrs. Sheila E. Dann.

— Nurse, Ontario, 52-11040.

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Input

Nursing diagnosis needed

In response to Jessie Mantle's letter of February 1977, we commend her for her timely questioning of the "appropriate clinical content" for *The Canadian Nurse.* This question has been on our mind for a long time.

We agree that nurses need "enough information about the pertinent etiology, incidence, signs and symptoms of a disease state," but, as Mantle contended, such information is obtainable from the medical journals and/or medical, nursing texts. What we need, in an attempt to help nurses improve their nursing care, is more than knowledge on disease states, we need the ability to problem solve.

A registered nurse is expected and has been taught to make professional judgments and decisions regarding the client situation. In order to do this, the nurse should be able to use the knowledge she possesses. Nursing diagnosis, as mentioned by Mantle, is the mechanism through which the nurse demonstrates her ability to apply scientific knowledge in the provision of patient care. Furthermore, the knowledge on disease states which we gain today may be outdated by tomorrow, because of the advancement of scientific and medical technology in our complex society.

Thus the issue to which we should address ourselves is not the knowledge on disease states, but rather, the thinking process. The clinical articles published in *The Canadian Nurse* should deal mainly with the areas on nursing diagnosis and nursing process.

— Shirley Wong, R.N., Julia Wong, R.N., Halifax, N.S.

Nursing intervention

I would share Jessie Mantle's concern regarding the interpretation of the term "clinical" and therefore the types of articles which would be acceptable for publication in the journal. I agree with your view that "...information about pertinent etiology... of a disease state ..." *if one exists* is important. But much of nursing care is or should be addressed to health-related problems in which no disease state is evident; sharing of information and experience regarding this care is important.

We have been concerned for some time about the whole question of describing patient problems amenable to nursing in terms which are conceptually consistent with nursing intervention, i.e., making a *nursing* diagnosis. During the past two to three years, we have been attempting to develop a listing or taxonomy of such nursing diagnoses; and at the present time, with assistance from National Health Research and Development funds, we are formulating a proposal to test the wider application of this approach.

This experience has brought me to the view that widely understood and accepted terminology describing *nursing* diagnoses (examples of which are cited by Jessie Mantle) would result in improved patient care plans and should provide the basis for a more precise description of nursing care and for evaluation of its effectiveness.

For example, it seems to me that if we are to benefit by Jessie Mantle's valued nursing contribution, we need to be attuned to the terminology of the problems with which she is assisting the patient/family to cope, e.g. fears of death, changes in body image, pain and changes in activities of daily living; furthermore, if we are to care adequately for patients, we urgently need to share our growing knowledge regarding nursing problems and our nursing intervention.

— Phyllis E. Jones, Professor, Faculty of Nursing, University of Toronto.

Abortion Pro and Con

As a registered nurse no longer employed in nursing, I find the present *"Canadian Nurse"* most valuable. I treasure my knowledge and past experience, but am most keen on learning new things and staying aware of what's happening now in nursing. I appreciate the case study type of article the most.

I commend you for the article "Abortion Counselling" by Easterbrook and Rust (January, 1977). Would that all centers had such a nursing team as does Toronto General Hospital. There is so much misunderstanding surrounding this issue, that many abortion patients are not getting the type of care that would be called optimum. I hope that other centers get inspired by the article so that abortion patients throughout Canada may benefit from the work at T.G.H.

Please keep up the good work. I find the magazine more interesting with each issue. Thank you!

— Barbara Cope, Reg. N., Otterville, Ont.

So, the Toronto General Hospital has set up a 'New Role for Nurses' — counselling women who have decided to dispose of their children before they are born. I wonder if this hospital provides such wonderful service to mothers with sick children — mothers who want their children to live?

This is one of your readers who would prefer you filled the pages of *The Canadian Nurse* with stories about nurses who are working in the field of preserving lives. Hopefully we are still in the majority. *— Name withheld, Powell River, B.C.*

As a nurse I am very disappointed in the article and disagree in the encouragement of nurses being involved in such counselling. In my opinion, this is a direct promotion of abortion when, today, there are so many alternatives, for example organizations such as Birthright and Right to Life which promote the life of the child.

— A Concerned Nurse, (name withheld) Charlottetown, P.E.I.

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News



Members of CNA's Special Committee on Nursing Research took a break during their recent two-day meeting in Ottawa to have their picture taken. Standing, left to right are: Rose Imai, Ottawa; Odile Larose, Montreal; Jacqueline Chapman, Toronto; Helen K. Mussallem, CNA executive director; Joan Gilchrist, CNA president, Montreal; Peggy Overton, committee vice-chairman, Edmonton; Helen Glass, committee chairman, Winnipeg; Margaret Rosso, Regina; Ada Simms, Carbonear, Nfld.; Lesley Degner, Winnipeg; Marion Kerr, CNA research officer. Committee members absent for the meeting were Margaret Scott-Wright, Halifax, and Pamela Poole, Ottawa.

During the meeting, held at CNA House on February 21 and 22, the committee prepared a review of the *Report of the Task Force on Cervical Cancer Screening Programmes* (the Walton Report) released last June. (See *The Canadian Nurse*, June, 1976).

Highlights of the review, prepared in response to a request from the Board of Directors of the Canadian Nurses Association, follow:

Comprehensive data base

The Report analyzed data from a number of sources. These data were not necessarily complete nor comparable and referred only to short time periods. With this kind of information, it is difficult to make valid comparisons between provinces or programs. In addition, international references to studies of cervical cancer were limited to research conducted in the Western industrialized nations. The committee agreed with the finding of the Report that in order to make meaningful comparisons:

- a centralized registry for cervical cancer is essential
- further investigation into developing uniform terminology is required
- standardized methods of reporting incidence and mortality rates are also needed.

This type of information must be collected over a long period of time so that longitudinal data are available in addition to cross-sectional data. Expert advice on the development of such a data base is essential to collect the right kind of data and to ensure that appropriate statistics are used when reporting comparisons.

Lifestyle factors

In addition to improving the reporting system, it would appear that more clear-cut evidence should be obtained from multivariate, multicultural research if lifestyle factors are to be used to identify risk groups.

Mechanisms of implementation

If the development of the data base on cervical cancer continues to justify the need for screening programs, possible strategies for implementation should be explored. The following general principles would appear to be important during planning stages:

- Implementation of programs should be decentralized and should allow enough flexibility to accommodate differences in medical practices and to permit the development of innovative methods in each province.
- Some coordination of proposed plans for implementation is necessary to obtain comparable data across Canada.
- Detailed planning of potential costs should be made. Provision must be made for the integration of new programs into the existing health and social services system so that current services are utilized advantageously and there is minimal duplication. Although the Report suggests that such a program will not require additional costs, during implementation phases it may be necessary to duplicate services as opposed to direct substitutions.
- A comprehensive educational program must be planned not only for health professionals providing services but also for the general public. Careful interpretation will be required when screening patterns change. When some routine services that have been accepted in the past, for example, are to be withdrawn or changed for women in certain age groups the women will need to be informed of the risks. Further, care must be taken that classification of women as "high risk" does not result in social stigma.

Evaluation

Plans for evaluation should be made when new programs are being developed. A requirement should be made, then, that each proposal for a screening program include an evaluation component. Careful monitoring and documentation of each program is essential and this information should be made available on a national basis. Expert consultation in program evaluation will be necessary to ensure that:

- programs are monitored
- valid services are being provided
- adequate follow-up is provided to persons for whom the present pattern of services is altered.

Orthopedic Nurses hold education day

Two and one-half years ago, a group of southern Ontario nurses interested in providing better care for the orthopedic patient got together and decided to "do something." Organizer Melanie Hitch contacted the American Orthopedic Nurses Association and with their help started what today is known as the Toronto Area Interest Group of the Orthopedic Nurses Association.

With an active membership of approximately 80 nurses, the group meets once a month to keep abreast of new trends and developments in orthopedics and ultimately to learn better ways of caring for their orthopedic patients. So far, the only other such interest group in Canada is located in Hamilton, Ontario with Irene Cummings as president.

One of the main objectives of the Interest Group was met in mid-February when they held their first education day . The conference was enthusiastically received by the 265 nurses who attended — nurses who came from all across Ontario, from London, Hamilton, Ottawa, Peterborough and as far as North Bay — to hear speakers discuss various aspects of care as it relates to the orthopedic patient.

Heather Reuber, President of the Toronto Area Interest Group and an O.R. nurse at St. Michael's Hospital in Toronto, introduced Dr. Robert McMurtry, orthopedic surgeon at the Sunnybrook Medical Centre in Toronto who discussed priorities and approaches in treatment for the patient suffering from accidental trauma in the light of his experience as a member of the Regional Trauma Unit at that hospital.

In reminding the audience of the importance of prompt diagnosis and treatment of traumatic injuries, Dr. McMurtry encouraged nurses always to have a sense of curiosity about "what else" is happening to the patient both on the wards and in emergency. Alert and questioning nurses can be instrumental in recognizing the less obvious injuries that might compromise a patient's life.

Dr. John Barrie, consultant

(continued on page 16)

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News

Ontario nurses document declining standards of care

When provincial governments across Canada initiated cutbacks and curtailments in health care spending, there was a cry of protest from the public and from providers of health care services, that cutbacks would result in a deterioration in the quality of care provided. Over the past year, the effects of budget restraints in health care delivery have varied from province to province. In an attempt to reduce the high cost of health care, some provincial governments have taken steps such as closing hospitals, cutting hospital budgets (a move which has forced hospital administrations to close beds and to cut staff), and allowing little or no increase in the amount of money available for nursing homes, home care, and community programs.

One group which has indicated concern about the effect of these measures on the quality of health service in their province is the Ontario Nurses Association. Recently ONA released a Health Care Review as an expression of concern with what it sees as "a decline in the Health Care Services in Ontario."

The report, researched over the past year by Barbara Linds, is the result of discussions held with representatives of local chapters of ONA, an association including 23,000 nurses across Ontario, nurses involved in many aspects of health care, from both urban and rural settings.

The report concentrates on eight major areas of concern: nursing homes and homes for the aged; psychiatric facilities; misuse of hospital facilities, beds, and services; wastage and unnecessary expense; high quality care at less cost; community nursing services; public health; and nursing workload and patient care.

In all, 41 recommendations for change are made, recommendations which the report states: "have been made time and time again in numerous studies, many commissioned by the Ministry of Health. To date, we have seen few of them implemented."

Although the recommendations themselves are not unique, the report is characterized by an unusually strong nursing perspective. Included in the preface to each group of recommendations are statements made by nurses about how they view the present health care situation. These are just a few of their comments:

On nursing homes

"We have forty patients on the chronic floor and twenty on the medical floor waiting to get into the home for the aged. Most of them die before they get in. They just built a new home in the area, and it's already full. We have 132 beds in our hospital."

On psychiatric facilities

"We know we are sending people back to home situations that are the same as the ones that sent them to the hospital in the first place, but there is not much in the way of follow-up in the community for them."

"We have a good psychiatric follow-up program in public health and we have a community mental health program. As well, public health nurses are involved, working with a psychiatrist in the community..."

On misuse of hospital facilities

"In our whole area, everything which could be done by public health, home care and doctors in their offices — it all gets focused on the emergency department."

"Since the 'cuts' we have had people in emergency for 24 to 72 hours waiting for a bed. Before, that was rare."

On wastage and unnecessary expense

"They built a fantastic new Intensive Care Unit nursery nine months before a specialized hospital was built in our area. Any newborns requiring specialized services are immediately transferred. We feel this is poor planning."

"When we send patients to other hospitals with test reports, they do the tests all over again."

On home care services

"Home care isn't as effectively used as it could be. It doesn't relieve hospital beds because patients aren't discharged quickly enough to use what home care was meant for in the first place. This is because doctors don't refer people."

"I have worked in the health unit for five years and don't remember once getting a referral from a head nurse."

On public health

"Our school health program has been cut back to less than one third of our time. If they don't see you in the school, they don't use you as much."

"In one hospital, we visit each new mother in the hospital. In another, we aren't allowed on the floor, because they don't like us bothering the mothers."

"Every year our number of visits increase by 2,000. No new staff. They increase our programs and don't evaluate the old ones. They just add on. Many staff respond to family requests on their own time."

On workload

"It's like a car wash — we attempt to give adequate physical care and that's it. Patients tend to get more information from the housekeeping staff because they are in the rooms more often."

"We cannot see the concern on the part of Administration for the patient. There is no longer patient-centered care. When we are understaffed the attitude seems to be 'it's too bad you'll just have to manage."

The report focuses on the areas of greatest concern within the present health care system, and proposes to bring these concerns to public attention, "to begin a process of questioning and discussion in our communities."

In conclusion, the report makes five broad recommendations:

- Restructure the present fragmented, overlapping, costly and inefficient health care services by developing a planned, coordinated, health care system with a shift in emphasis from the acute institutional care concept to preventive, supportive and rehabilitative community health care.
- Involve citizens and health care workers in all aspects and levels of planning and evaluating health care.
- Identify and validate community needs, from which appropriate programs would be developed and funded accordingly.
- Continuously monitor programs to provide flexibility in meeting the changing health needs of the public and to provide appropriate value for monetary support.
- Delegate responsibilities and functions to health workers based on a comprehensive assessment of their abilities to contribute.

Health happenings

A group of Japanese nurses visiting the offices of the *American Journal of Nursing*, had some tips to offer prospective participants in the 16th Quadrennial Congress of the International Congress of Nurses. Among the questions they answered, according to a report in the February issue of the AJN:

How expensive *is* Tokyo?

- A nurse who passes up the more elaborate dining rooms in favor of small neighborhood restaurants, can manage on between $10 and $20 a day, including transportation, but excluding hotel costs.

What about shopping?

- Finding English-speaking sales people is easy in large shopping centers but not to be depended on elsewhere. A number of Japanese nurses have, however, volunteered to act as guides.
- A souvenir shop will also be available at the site of the ICN meeting.

Food and drink?

- If you insist on coffee you would be well advised to carry your own instant variety, available in Japanese markets.
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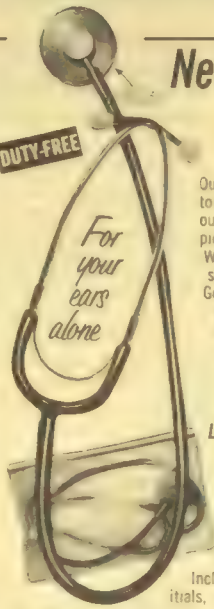
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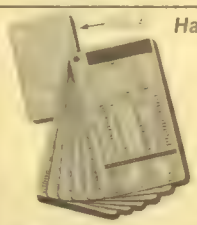


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News

(continued from page 12)

pathologist at the Toronto East General Hospital and at the Orthopedic and Arthritic Hospital, Toronto, believes that pathology can be fun. Humorously and with great ingenuity, he reviewed the pathology of rheumatoid arthritis and described the marvels of cartilage. His advice to old people was: "Lengthen your stride." Joints which don't stretch or extend to the fullest, he said, quickly become useless. He encouraged nurses to be sure that the older patient walks with a long stride — "It will add ten years to your patient's life."

One problem the orthopedic nurse faces lies in making the correct assessment and giving the appropriate treatment to the patient who complains of "pain." Vahe Kehyayan, faced this problem as a nursing student when working nights at the Orthopedic and Arthritic Hospital in Toronto.

The patient may say "I have pain," but he may mean something quite different. Kehyayan now, psychiatric nurse consultant, stressed that patients should have a choice in the treatment of their pain.

A highlight of the day was the panel presentation of a nine-member patient care team from the Orthopedic and Arthritic Hospital consisting of an orthopedic and arthritic specialist, orthopedic surgeon, primary nurse, pharmacist, dietician, physiotherapist, occupational therapist, social service student and the hospital coordinator of home care. Dr. Swanson, Director of the Arthritic Service, explained that the entire team meets on a bi-weekly basis to discuss each patient and plan his assessment, treatment and evaluation. Using the problem-solving approach, they focus on the *person* who has the disease rather than on the disease itself. Everyone on the team, contributing his/her unique knowledge of the patient, assesses the problems and suggests possible solutions — solutions not only to medical problems but also financial, emotional or family difficulties the patient might have. In this way, they believe that the "whole" patient is cared for and that the end goal of effective daily living is met.

The concluding speaker was Dr. Robert Salter, Professor of Orthopedics at the University of Toronto and Chief Surgeon at the Hospital for Sick Children, widely recognized for the inominate osteotomy (known in other countries as the Salter operation) used in the treatment of Legg-Perthes disease. In his talk, he touched on the physiology of Legg-Perthes disease and current treatment. Adding weight to the previous discussion of total patient care, Dr. Salter emphasized the importance of the "child's head" as well as the "femoral head" in deciding on treatment — whether it be surgery, a brace, casts or bedrest.

At the end of the day, president Heather Reuber announced that the Interest Group was hoping to make the orthopedic day an annual event.

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Sixth Edition, **Virginia Henderson, R.N., A.M.,** and **Gladys Nite, R.N. A.M.,** with 17 contributors

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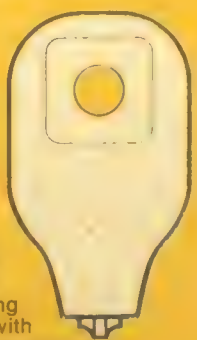
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By Margaret Jensen, R.N., M.S., Ralph C. Benson, M.D., and Irene M. Bobak, R.N., M.S. April, 1977. Approx. 832 pages, 8½" × 11", 659 illus. About $18.40.

Maternal/Child

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2nd Edition! **TEACHING CHILDREN WITH DEVELOPMENTAL PROBLEMS: A Family Care Approach.** *By Kathryn E. Barnard, R.N., B.S.N., M.S.N., Ph.D. and Marcene L. Erickson, R.N., B.S.N., M.N.* This helpful text presents both the rationale and specific approaches for teaching young children and infants with developmental disabilities. It can help students develop the creative problem-solving skills and sound strategies demanded in daily care and management. This revision incorporates the latest information on child development and handicapping conditions, family reactions and strategy planning, and methods for observation and assessment. Emphasis is on parental roles and nursing responsibility — a new chapter fully explores how nurses can work with parents in the group setting. 1976, 194 pp., illustrated. **Price, $6.60.**

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Senator David Croll. Final Report of the Special Committee of the Senate on Aging. Ottawa, Queen's Printer, 1966.

The dependable volunteer in the community is always in great demand. Nurses who share their caring qualities with fellow community members, and not confine themselves to institutions and "patients" can add an extra dimension to their own lives and the lives of those they help.

A Caring Experience

Mary Bawden

Four years ago, in London, Ontario, a group of concerned professionals that included several nurses, a social worker, an occupational therapist, and the executive director of a community agency, got together to create a citizen advocacy program that came to be known as "Friendship in Action."

This program has two target groups: senior citizens living alone in the community, lacking family support, and the adult retarded. Based on a concept developed by Dr. Wolf Wolfensberger of the National Institute on Mental Retardation, the program provides a service to individuals who are lonely and/or isolated but who, with the friendship and support of another person, could become more active, independent, and fulfilled.

In addition the advocates (volunteers) are expected to speak for and represent their friends (protegés) in problems of their rights in obtaining full benefits as community members.

The volunteer helps his friend meet whatever needs become apparent for social contact, new experiences, emotional support, professional services, etc. He or she offers a very personal relationship that differs in quality and scope from the service offered by professionals, but complements and facilitates their work.

Volunteers need much the same personal qualities as nurses working in the field of geriatrics — a warm and friendly personality, dependability, good judgment, and a deep regard for human beings and their rights.



How "Friendship in Action" Works

Mrs. F. was a seventy-eight-year-old widow who lived alone in a Senior Citizens' Apartment. Her husband, four sons, and a daughter had all died years ago. She was a very lonely lady who found it difficult to understand why she had been spared and why she must continue to go on living.

Mrs. F. suffered from a mild case of diabetes — controlled by diet and tolbutamide — and from fairly severe osteoarthritis. Her osteoarthritis was mainly in her knees and hips, greatly limiting her mobility. She was therefore unable to get out on her own to shop, and relied on neighbors to pick up the odd thing.

When I first visited Mrs. F. as a citizen advocate, I found an elderly white-haired lady, very tall and thin, with a distinct twinkle in her eyes. Her crowded little living room was filled with old photographs of her family and friends from years gone by. Mrs. F. had a fantastic memory and having always lived in the City, would tell me all kinds of historical facts, and could chronicle many of the architectural changes over the last sixty years. She also told many stories of her family and their growing-up years. Having sung in her church choir for years, often as a soloist, Mrs. F. enjoyed a singsong, but didn't take kindly to those who sang louder than she, and off-key to boot. She knew everything that was going on in her building and would tell about it in her own inimitable sarcastic style.

Much of my time with Mrs. F. was spent visiting, listening to her stories and telling her a little of my life and family. Within a short time, we were friends in the true sense of the word.

Mrs. F. enjoyed any contact with the world outside her apartment so when weather permitted we both went grocery shopping, made the odd trip to the farmers' market or a local shopping mall. Sometimes we simply went for a drive through the park that she remembered from Sunday School picnics sixty years earlier or to the cemetery where her husband was buried.

Being a very realistic, down-to-earth person, Mrs. F. prepared to give up her apartment when she could no longer reasonably manage, and moved with her T.V. to St. Mary's, a hospital for the chronically ill. She did not regard this move as in any way a defeat but remained active, wheeling around in her chair, keeping track of the nurses and attending O.T. during the week.

In good weather, I pushed her in her wheelchair around the block, gathering Fall leaves.

Mrs. F. died very suddenly of a myocardial infarction in the middle of the night, just before her eightieth birthday. It was the way she hoped to die, not lingering, not being a burden. All her funeral arrangements had been made in advance and her favorite daughter-in-law from Western Canada flew down to officiate.

Mary Bawden, *Reg. N., B.Sc.N., who wrote "A Caring Experience," is already familiar to readers of* The Canadian Nurse *through her Clinical Word Search Puzzles which have appeared at intervals over the past year. She was recently named president of the Board of Directors of Friendship in Action, the citizen advocacy program she describes in her article.*

An active member of the Registered Nurses Association of Ontario, she is president of the Middlesex North Chapter of the RNAO and has served on numerous committees and working parties of her professional association. A graduate of South Waterloo Memorial Hospital School of Nursing in Galt, and of the University of Windsor, she is currently Team Leader in the Rheumatic Diseases Unit of the University Hospital in London, Ontario.

Practical Concerns for Nursing the Elderly in an Institutional Setting

Myrtle I. Macdonald

Physical and psychosocial needs of the elderly are closely interwoven. Within the constraints of time and budget, there are many steps that nurses can take, on general or geriatric wards, or in the community, to meet these needs and to improve the general sense of well-being of those who are old. Careful attention to details of nursing care — changes that don't require major expenditures of time or money — can make all the difference in the world to these "senior citizens" ... can make it possible for them to become more mobile, to present an attractive appearance, hear and see better, eat and sleep better, avoid problems of incontinence and constipation, and prevent respiratory problems.

When this happens, they feel a sense of mastery over their environment, become more alert and aware of their surroundings, and benefit from more productive relationships with their family, friends and community.



Photo courtesy of Health and Welfare Canada

a Physical Care Goals

I Maintaining and improving muscle coordination and ambulation

Musculo-skeletal changes

— decreased muscle power and strength
— decreased mobility of and stiffness of joints
— increased susceptibility to fractures
— prolonged healing of fractures

Nursing measures

1. Wheelchairs and feeding chairs

• An adequate supply of both wheelchairs and feeding chairs makes it possible for patients to get about, to leave their rooms, to dine and enjoy social activities. This is a mixed blessing, however, for ambulatory patients rapidly lose their ability to walk if you do not take time to walk with them.

2. Walking

• It takes time to assist an elderly patient to a stable standing position but this is time well spent since just one or two weeks of sitting is enough for the hips, knees and ankles to become flexed in a rigid shortened position and calcification to set in.
• Often it takes longer to help a person get up and walk to the dining room, for example, than to lift him into a wheelchair and push him there. Plan your daily schedule to allow for this; start helping patients walk to the dining room long enough ahead of the arrival of trays to avoid rushing.
• When walking with an individual patient use encouraging, ego building words to say, 1) walk tall (which is more effective than saying "straighten up," 2) lift your knees, 3) have a wide base with feet far apart, and 4) point your toes forward.
• Exercising of legs and knees, ankles and toes, just before standing up to walk, helps patients get the idea of using their joints more flexibly. The *quadriceps plant* is an exercise that nurses can readily teach. It consists of having the patient press down the back of his knee and lift his heel, by tightening his thigh muscles. This can be done either lying in bed or sitting in a chair. It helps the patient to learn the exercise if the nurse places one hand under the patient's knee and the other hand under the heel, to raise it passively, slightly. After the patient understands how to do the exercise actively, only verbal encouragement is needed to keep him/her performing the exercises q.i.d.

3. Enriched program of physical activity

• The provision of an enriched program of physical activity to keep all joints mobile is an integral part of nursing. Include it in your schedule on each shift, and, as well, try to arrange referrals to both volunteers and other disciplines. Many nurses do not realize that Occupational Therapists are adept at teaching activities of daily living, devising appliances where needed. It is also part of their function to retrain fingers using dynamic splints and other equipment.[1]
• The elderly can become almost as agile as youths even if they do not start to train for flexibility until late in life. They can learn to dance or do gymnastics. Yoga has been found to be surprisingly suitable for the elderly as it does not demand quick movements.[2, 3]

a) Group Games

• Some patients walk about a great deal, and it is common to assume that they are getting enough exercise. However, closer observation reveals that many of these patients have lost their ability to tie bows, do up buttons, bend over and put on shoes, and raise their arms above their heads to dress themselves and care for their hair. Why does this happen when for decades nurses have been encouraging patients to maintain self-help? One reason may be that using the required muscles only once or twice a day is not enough to keep them functional. Other ways need to be found to keep the joints and muscles limber through frequent use.
• Group games in which rings are moved on a string, soft balls are tossed, or beanbags or suction darts are thrown are ideal for exercise. Lawn bowling and horseshoes entertain many elderly people. Once a week is not enough. Morning, afternoon and evening varied activities that encourage use of shoulder and hand muscles, should be planned.
• In one hospital, a group of volunteers goes to a geriatric ward to lead a group meeting called Remotivation-Therapy.[4] They include action songs such as "Under the spreading chestnut tree." They have given a good deal of thought to selection of songs that appeal to the elderly, and they make up actions to go with the songs.[5] They have found that the music must be very slow and repetitive, and that sometimes even one stanza of a song is enough to keep the people actively participating for some time.

b) Group exercises

• In another large institution a representative of the recreation department comes to the geriatric ward two or three times a week to lead group exercises. He sits on a stool in the middle of a circle of people seated in armchairs, uses traditional physical education movements of arms and legs and head, and each day adds something new or different for variety. To promote better range of motion of head and neck, he has them turn to left and right, as well as lean forward and hyperextend their necks backward. He also gives attention to the abduction of the legs and the lifting and extending of the knees. These movements are vital if nurses want to keep patients from scissoring their legs and permanently flexing their knees in the fetal position.
• If left to chance and spurts of enthusiasm, exercising is soon neglected. Nurses can reach out into the community to find volunteers, but then you need to guide and encourage these volunteers, working along with them to supplement what they are doing. The time this takes is actually not great and results, eventually, in a lightening of the nursing workload.

4. Consultation and referrals

• Physiotherapy is a must for every geriatric patient and nurses need to be familiar with the exercises and goals of each of their patients. This is especially true when the treatment is given off the ward. Often a patient carries out quite advanced maneuvers with the physiotherapist, but gets away with sedentary behavior on the ward. If you know what is going on, your expectations will be consistent with those of the physiotherapist, and you can reinforce the teaching provided.
• Recently, there have been great advances in nursing in the specialties of orthopedics, rehabilitation, and rheumatology. The nurse who devotes years to geriatrics may easily become outdated in these fields, and without knowing it deprive her patients of the benefits of these advances. Sabbaticals to practice for some months in these other fields would help to solve this problem.
• Many nurses are timid about providing exercise after a fractured arm or hip and, as a result, their patients do not regain function. Exercises are started too late and not carried out t.i.d. Pain is usually a result of disuse and favoring of muscles, rather than injury.

II Looking and feeling better

Integumentary changes

— hair loss
— skin dry with decreased turgor
— skin mottled with pressure sores
— slow wound healing

Nursing measures:

1. Personal needs and clothing

• An adequate supply of shoes and clothing is a must. Usually this is provided by relatives and special funds. If not, nurses can take steps to see that pension cheques are withdrawn from hospital trust funds, signed, and money made available to relatives to purchase what is needed. (The same sort of initiative is required to obtain trips to a podiatrist when nails are too horny for nurses to trim).
• Relatives may need advice about suitable purchases: slippers need to provide firm support for walking and be washable for those who are incontinent; they may need to be larger than formerly due to edema as heart failure develops and circulation slows down. Clothing needs to be attractive, easy to launder, wrinkle-resistant, and long enough to avoid embarrassment when sitting in a low chair.
• The appearance of elderly patients can be enhanced by the provision of full length mirrors, a laundry and ironing room, and a seamstress to help with mending at least once a week. Integration of wards for both sexes promotes greater attention to grooming. Excursions for shopping and social events, and weekend and day passes further promote maintenance of an attractive wardrobe and appearance.

2. Teeth

• Care of the teeth of the elderly needs very careful planning, for confused patients lose their tooth brushes and even their dentures, and stiff fingers make self-care difficult.
• Nurses frequently find the cleaning of dentures unpleasant and so there is a tendency to slip up on it,sometimes for days at a time. Therefore the head nurse needs to find a method of holding nurses accountable for their care. A graphic sheet similar to a medication sheet, initialed t.i.d. could be one answer. Perhaps there should be cards for mouth care and other treatments similar to medication cards.
• Tooth brush racks and shelves should be attached near the sink, and some consistent method of sorting tooth brushes worked out so that changing nursing staff can count on finding the tooth brush where it is supposed to be, and thus save steps and time. The patient's name should be attached to brushes and other toilet articles. Could dentists be asked to engrave the name of the owner on dentures?
• When teeth do not fit, visits to the dentist for adjustments may be arranged. One reason why people put up with ill-fitting dentures is that they do not realize anything can be done about it. Why should pension cheques accumulate and go unused? Sometimes relatives would be glad to take the patient to the dentist since this offers them some concrete and constructive way to help.

3. Cleanliness

• Bathing elderly patients can be a heavy task but tub baths or showers at least twice a week are necessary to keep skin intact and prevent rashes. Only those with a new surgical incision or a plaster cast should be given a bed bath instead. A shower can be given with the patient sitting on a stool. Well positioned hand rails need to be provided.
• Bathtubs should be at least four feet away from the wall on each side, so that patients can be transported into the tub by a portable lift. Four or five sets of canvases are needed for each patient so that they can be lowered into the tub. This is not a great expense; many a lift goes unused because of shortage of canvases and unfamiliarity with the equipment. Those who are accustomed to their use find that patients feel secure in them, and that bathing is greatly facilitated, and takes less time and energy.
• Shampoos should be given at least once a week, and a record kept of them, for it is easy to slip up on hair care. Ward supplies of shampoo and deodorant are needed.

4. Skin Care

• If the goal of improved ambulation is met, there is little opportunity for skin breakdown from poor circulation and pressure. To prevent skin breakdown from pressure areas, patients should sit in a variety of chairs and not favor just one chair.
• Turnings are necessary at night. The prone or semiprone position should be required for at least a short time every night, long before there is a pressure area on the coccyx and each hip.
• Because muscles adduct and shorten from much lying in the fetal position, plus sitting in chairs, it is really important for the patient to counteract the tendency to curl up in bed. Even after the fetal position becomes habitual, it is possible to extend the legs gradually; they yield to firm slow pressure more readily than to quick movements.
• Nurses tend to assume that sheepskins are expensive and hard to obtain. Actually, with adequate planning, a large supply of inexpensive synthetic sheepskins can be maintained. They may be washed in the hospital laundry by ordinary methods.

III Remaining alert and aware

Sensory changes

— decreased vision and hearing
— decreased taste and smell
— decreased tactile sensation

Nursing Measures

1. Hearing

• Many older people have trouble becoming accustomed to hearing aids. They should be encouraged to lip read; some can do so already but are unaware of it. If they begin to recognize their ability they can improve it by watching the speaker more carefully.
• Speaking slowly and clearly to a partially deaf person is not easy. Sentences should be short. The voice should not drop. Above all, before saying very much to the person, you should make sure that he is listening. What passes for deafness is often just not knowing that he is being spoken to, and not being given time to tune in.

2. Vision

• Loss of visual acuity creeps up on many people so gradually that they are unaware of a visual problem.[6] Sometimes the reduced ability to see is attributed to emotional problems. Loss of interest in sewing, reading, carpentry, or

repairs is often not recognized as being due to need for glasses. Many retired persons have never had glasses; most have not had their eyes tested for a long time.

- Nurses should make sure that eyes are examined. Just to advise patients to have such an examination when they return home is not enough. Most will not carry through the advice. They need support each step of the way until they have the glasses and have learned to use them with ease.

IV Eating better

- Those who have lived alone often come to hospital in a malnourished state, having relied too much on tea and toast. Initial finicky eating soon gives way to a better appetite. An appealing diet even of minced foods can be provided.
- Whole grain breads and biscuits (rather than white bread, cakes and cookies) should be made available. Real rather than artificial fruit juices should be used because of their lower sugar content and higher nutritional value.
- Reducing diets are important, not only to make the patient more mobile, but also to increase his sense of self-esteem and well-being.
- Those who live at home or will be returning to their homes, need help in the selection of nutritious, inexpensive foods. Going over the weekly grocery advertisements with them is one means of discussing the relative merits of foods. A useful guide is the Nutrition Canada survey.

V Avoiding incontinence

Urinary tract changes

— urinary retention
— urinary incontinence
— oliguria, nocturia

Nursing measures

1. Increasing fluid intake

- Elderly people often try to correct incontinence by decreasing their fluid intake. However, an inadequate fluid intake tends, among other things, to lead to urinary tract infection. Infection in turn increases incontinence. It is important to treat the infection with appropriate medications and to increase the fluid intake.
- Bladder training like that carried out in rehabilitation centers may be useful. One such regime is a large fluid intake combined with training in regularity of urinating, and provision of an environment that stimulates reality orientation and relieves monotony.[8]

2. Improving communications

- It is a good idea to make individualized plans to assist patients who have to urinate at night so that they can use the toilet, commode, bedpan or urinal. If they realize that you will come to their rescue, they will try to control their voiding.
- New types of call lights that can be activated by those with limited finger function are especially useful.[9]
- Intercom systems also make life easier for both you and the patient.

VI Preventing constipation

Gastrointestinal changes

— constipation leading to fecal impaction
— fecal incontinence
— malnutrition

Nursing measures

Fiber intake

- The increase of fiber in the diet, especially in the form of whole wheat bread and natural bran, is advocated by many authorities, including Denis Burkitt, leading speaker at the Miles Symposium of the Nutrition Society of Canada, June 1976.[10, 11]
- The normal stool should be large in quantity and soft, rather than formed. Hemorrhoids, diverticulitis, constipation, and varicose veins have been attributed to unnatural, highly refined diets peculiar to western society with its emphasis upon white breads, cakes and sugar. Diverticulitis should not be treated with a bland diet, but rather with an increase in intake of natural bran.

2. Fluid intake

- Increase in fluid intake is important for the correction of constipation. Of particular value is the intake of several cups of hot fluids early in the morning. The natural time for defecation is after breakfast, so the schedule should be planned to promote unhurried toileting at this time.

VII Obtaining adequate rest

Changes in sleep pattern

— wakefulness
— worry

Nursing measures

1. Aids to sleep

- Western society loses a lot of sleep worrying about loss of sleep. It really does not matter how much we sleep: the need for eight hours of sleep on the average is a myth that has terrorized many people. A happy night in which one reads, writes, meditates, has some hot milk or tea and a snack may well be as restful as a night in which one sleeps all night.
- Sometimes people cannot sleep because they are hungry, and do not recognize the problem.
- You can help by taking the time to listen to a distressed person, giving support to think through his problem, which might be too overwhelming to face alone.

VIII Preventing respiratory distress

Respiratory changes

— dyspnea
— orthopnea

Nursing measures

1. Deep breathing

- Frequent changes in position and deep breathing exercises are essential to prevent pooling of secretions and subsequent development of pneumonia. As on surgical and

medical wards, no less on geriatric wards, nurses need to teach deep breathing and coughing. It takes weeks of specific practice for anyone to develop a strong diaphragm and good chest expansion at the base of the lungs. The inspiration should be made quickly and the expiration very gradually, evenly, and completely, as in singing or swimming. Sudden expirations tend to trap air in the alveoli and lead to emphysema.

- It should be accepted practice for physiotherapists to make rounds to all geriatric patients giving chest physiotherapy if indicated, and ensuring that deep-breathing exercises are being carried out well.

2. Humidification

- Humidification of air in the winter months should be standard practice. Steam heating does not humidify the air, for the steam stays within the ducts. Humidifiers of various sizes can be purchased. There are inexpensive table models in which a motor rotates and a fine cool mist is produced.
- Warm steam humidifiers are not recommended, as the output of steam is small and the droplets are too large to reach the alveoli of the lungs.
- An inexpensive rotary drum humidifier can be installed in hot air furnaces. This rotates whenever the heat turns on, and the fan sends the hot dry air over the drum before it moves up through the air ducts into the rooms.

b Psychosocial Care Goals

I Mastering the environment

Behavioral changes

— confusion
— disorientation
— forgetfulness, poor short-term memory, shorter attention span
— depression, anger

Nursing measures

When most of the goals of physical care are being met in an optimum manner, there is likely to be a real sense of mastery, particularly if the person is permitted choices, and consideration is given to individuality. Of particular value is ability to move about the community to make arrangements to attend concerts, social events, and church and go for walks in parks and shopping malls.

1. Orientation to reality

- Ideally windows in the building will be set low enough for patients to see the grounds from a seated position. Also, when walking with patients, nurses can take time to pause by a window to let them look out.
- Furniture may include a clothes cupboard, dresser, desk and book shelf. As far as possible, patients in long-term facilities should be permitted to use their own prized furniture. It is unfortunate that many elderly people have been so depersonalized that they are no longer allowed to use an antique desk or have a treasured oil painting on the wall opposite their bed. Shelves for a few books, ornaments, plants and a couple of teacups are also appreciated.

2. Overcoming depression, anger

- People who are self-centered or confused may be that way because of depression. The loss of spouse, family home, or a special friend often results in mourning. Malnutrition and physical illnesses or disabilities further increase their sense of loss. You can help these persons resolve their mourning by understanding its stages,[12] accepting them as a natural part of grief, and not looking upon them as "difficult patients." Be willing to listen to their story repeatedly — each time helping them move on a little toward resolving another facet of grief. As their grief becomes less overwhelming, they are gradually able to appreciate people and the little pleasures of daily living.

II Better family and community relationships

Changes in social habits

— narrowing of interests and activities
— social disengagement
— loneliness and insularity

Nursing measures

1. Adjusting to a new lifestyle

- Some residents have chosen to live in a long-term residential setting. They are happy to have at last found a place to live where they can give up some of their responsibilities, and, at the same time, appreciate the comforts of a gracious setting where they are no longer lonely. They move in and out of the residence to maintain ties with the community. In fact, it may be easier now to get out to concerts and social events. They may even have a new urge to take on some volunteer political or cultural responsibility in the community.
- Other residents have been placed in similar settings against their will by relatives, and as a result, barriers of resentment and a sense of rejection and loss of self-esteem have developed. Nurses can help them improve relationships with their family and the community.

2. Interpersonal communications

- Every elderly person has a wealth of experiences and wisdom. Over the course of a lifetime, each of us develops a belief in the dignity of our own lifestyle. In order to maintain or restore this "ego integrity," elderly patients need to know that those who are caring for them appreciate and understand them as individuals.

Nurses can do a great deal to help patients express themselves more effectively. You could, for example, help patients to make up scrapbooks to display their photos and mementos. Sometimes relatives can assist in this project by bringing in clippings, sorting pictures and writing captions.

- When relatives are unable to help, volunteers can be found to give a hand. Sometimes a family would be pleased to "adopt" a grandparent when their own grandparents live far away.

3. Remotivation therapy

- A very effective means of encouraging people to talk about their interests and views is Remotivation Therapy. This is a group method which promotes growth in the "unwounded" side of the personality. It was originally used for people with chronic mental illnesses, with remarkable results. Seriously

withdrawn people began to talk again and dormant talents came to light. In recent years its use has spread to a variety of age groups and settings, including nursing homes and geriatric wards.

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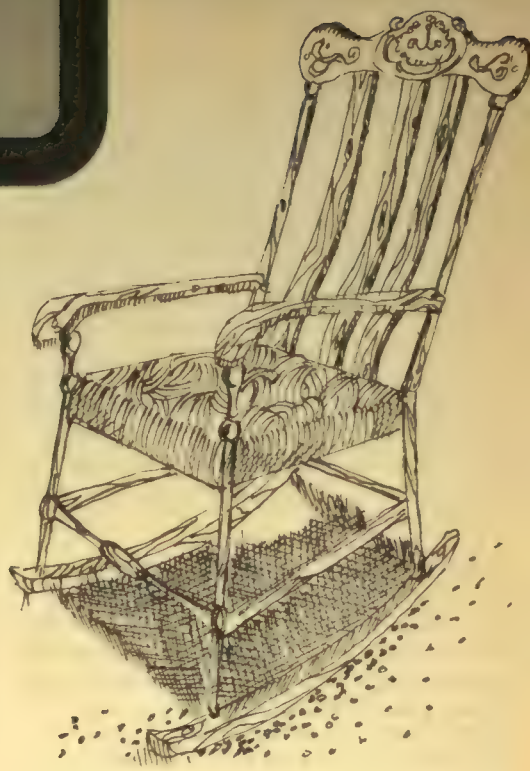
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"...to go home now..."

ANOTHER LOOK AT NURSING HOMES



Lynda Ford

For many nurses, the idea of working in a nursing home is less than inspiring. Nursing homes have the doubtful distinction of being a last resort in career choices; they are seen as depressing institutions where work is routine and centers around custodial care. In many cases our negative attitudes go untested; many of us have never been inside the doors of a nursing home. So let's take another look ...

The Florence L. MacKenzie Downtown Convalescent Centre is an unobtrusive four storey building just opposite the bus terminal in downtown Hamilton, Ontario. From the outside it looks like a rather ordinary apartment building.

Inside, it is a friendly community, the family numbering 105 members, people who have much more than age in common. The staff and patients communicate freely and work together closely. The second and third floors of the building room the more active members of the nursing home. The fourth floor residents need more nursing care; they tend to be confused, they are 'wanderers'.

I visited the MacKenzie Nursing Home to talk to the nurses there, nurses pleased to share their involvement and ideas about the community where they work. I came away after talking to nurses and visiting patients in the home with impressions that were strongly positive. Nursing homes seem to exist in a world of their own. At the MacKenzie Nursing Home, both the nurses and patients seem to have a lot to share.

Q. Let's start at the beginning, with why you decided to work in a nursing home. How did you end up working here, Joan?
Joan: It was a new concept of nursing for me... that's why I was interested. I really had no idea *how* you worked in a nursing home. I'd really never been in a nursing home before except to visit my grandmother, and you look after yourself there. So Mrs. Godzisz was talking about working here, and I thought I would come here and see what it was all about.

Q. Were you coming out of a hospital setting?
Joan: I hadn't really worked for quite a while, and my last job had been working with retarded children. Before I started here, I wasn't doing much of anything, and thought I'd like to start back.

Q. Did you find it took some getting used to?
Joan: Oh very much. It was the complete opposite of what I had been used to working in a general hospital. Policies and those types of things were quite similar to those I had known working with retarded children. But it's a real change from an active hospital.

Q. How about you Sophie? How did you get started?
Sophie: Well, for myself I wanted to get out of the hospital setting. I felt that I had spent my years there and left it for the younger girls — they're a lot busier now, especially now with cutbacks. I've always liked older people. I wanted to get into a new area, and I hadn't worked for four years or whatever it was at the time. So I thought that there were various areas that I hadn't been in — doctors' offices, clinics — actually nursing homes hadn't really entered my mind. I had been watching the newspaper and I'd see these ads come up for various nursing homes .... I thought — now that might be something different — and geriatrics was something I didn't know that much about. One day I saw an ad in the paper for a nursing home that sounded interesting, and I thought — why not, I'll just put in my application and go from there — well, I walked in the door and had a great reception because Mrs. Smith was here, and of course we knew one another from the hospital . So I was introduced, went on a tour of the home, and I was impressed. It looked like a nice setting, something I'd probably like to work in. And since I appreciate older people anyway — I think they've got a lot to tell you and there is so much to learn from them — I accepted, and I've enjoyed it since then — very much.

Q. How about you Mary Ann?
Mary Ann: I left the hospital setting and came directly to the nursing home. I was really searching for something else — working in intensive care was starting to become the norm instead of the 'abnorm', and frustrations had really piled up. The way my work in the hospital was going at the time — well, going into the hospital was becoming very tedious. I'd go in and never know what I was going to find when I got there. I began to think "there's got to be something better ... something different." I had probably exhausted myself of hospital settings. I saw an ad in the paper and thought I'd be interested in some part-time work. I came and applied, accepted a position as a part-time R.N., and worked my way up to where I am now.

Q. Many nurses express the complaint that they feel very powerless in a general hospital setting, more particularly an ICU setting. They get a feeling that they're just carrying out orders, that they haven't much to say about long-term goals for the patient, that they're caught in a big machine. Do you find your position radically different here? Do you generally feel you can use your initiative more?
Sophie: I think that if you talk to the girls working in hospitals, you'll find that they leave at the end of a shift with a great feeling of dissatisfaction and frustration. It's a real pressure situation from what I can understand, and it doesn't seem to be easing. Here, with our patients, we've got a good rapport, and we feel totally responsible ... I almost get possessive ... I care so much for them and want the best for them. In a hospital, you've got short stay cases, you don't necessarily get to really know your patients in a hospital setting ...

Q. And so you can't make a realistic assessment of what might be best for them?
Sophie: Hospital settings don't give you the right to do it ... because you're strictly on doctor's orders, whereas here there's more flexibility ...
Mary Ann: ... And we have better communication with doctors here in our nursing home. We can discuss with them and make suggestions. They'll say "Well you know that patient 24 hours a day, and know what he is like" and accept suggestions. You don't get an "I am the doctor ... You do this." pose. We talk cases over with the doctor and suggest changes and this brings a lot of satisfaction. We also really get to know the relatives and working with the relatives really makes our job a little nicer.
Joan: One thing that helps is that this is altogether a different atmosphere — these people really aren't sick and we're here to help them enjoy the last few years of their life in most cases. I think that this is why we have such good relationships with everybody — doctors and visitors and patients — because they aren't really sick, they're here because there's really no other place to go, and we're here to help them along.
Mary Ann: The family can't be with them day and night and have reached the point of no return — where they have to let someone else take over so that they can continue to enjoy them. Otherwise there are family breakups — we have a positive role in helping to stop that.
Joan: We're in a different category — we can't even class ourselves with hospital work — it's a world of its own ...
Mary Anne: Well, I think, Joan that nursing homes are like what we used to know in medical floors with their long-term medical patients ... you really got to know those patients, and got satisfaction from doing more than just active treatments ... you were there to help them along. In really active settings you just don't have the time to spend with the patient.

Q. Do you feel now that you have enough time to spend ... if a patient needs more time, can you give it?
Joan: Most times, yes — there are a few days when just nothing goes right and you don't have time for anything, but most days there is more time just to get to know people.

Q. What about the comment that many people, including nurses make — that nursing homes are depressing places to be. You people incidentally don't seem to be depressed.
(Laughter)
Sophie: Well, people get the picture of a dungeon of old sad people lying around like little skeletons. They think it's a terrible atmosphere...
Joan: It's just lack of education of the public — that's what it is. The people here just aren't sad — and that goes for staff and patients.

Q. How about the patients? Coming into a nursing home I guess they might feel pretty sad at the beginning?
Joan: That I think, depends on your patient...
Mary Ann: ... Not on the fourth floor, but on the second and third floor we often see an initial depression. Our fourth floor is what we consider to be our senile floor — still ambulatory, they're wanderers and very forgetful. Patients on the second and third floors are our more alert patients — they know what is going on, are able to talk for themselves and make their own decisions. Sometimes they have problems at first.

Q. Can patients bring anything with them to make them feel more at home?
Mary Ann: Definitely yes. If they are in a private room they can bring in anything they want — fridge, television set, a bed, anything they can bring in. Ward and semiprivate patients can bring in a T.V. set if there isn't already one in the room ... their own radios, a special chair that they like, pictures, a lamp for their bedside table, chest of drawers. They are allowed their own telephone with a private number that doesn't go through our switchboard, and that really gives them a feeling of independence.

Q. Do you encourage the residents to look after themselves and their room as much as possible?
Mary Ann: If they are able to ... An alert patient is still able to look after himself. We don't strip him of the privilege of looking after himself because you can only deter him by doing that. It's important to keep patients as active and interested as possible, and this is one way of doing it. We also encourage them to go into different programs that we have at the nursing home ... to visit back and forth with each other ... and this keeps them pretty active.

Q. What programs can residents get involved with while they are here?
Mary Ann: Our residents get physio every day. They make crafts — we have a showcase on the main floor where we display their crafts and they go on sale. The patients get a percentage back of whatever is sold. There is bingo once a week ... and our patients think that it's terrific that there is no charge for bingo here. They win prizes. There's a monthly birthday party for residents that have their birthday that month, and everyone attends.

Different volunteer groups come in to entertain. We hold two non-denominational church services a week and a full Roman Catholic service once a month. They see movies once a month, and more often if we can get them. We have library services for them and get books with large print. For patients who can't read, we get talking books that they can sit and listen to. There's always something going on. I have to smile at some of the patients come Friday at 3:30. They say 'Well now we've got the weekend to rest.' Some patients ask Margaret, our therapist, for some work to do over the weekend. I think they're busy.

... We have a lovely roof garden in the summer and we hold barbecues or picnic lunches on the roof. The chef will prepare something special for these occasions. I've brought in live entertainment for our roof picnics and everyone seems to thoroughly enjoy it. Some patients really prefer not to go out the front door, but after a barbecue on the roof will say what a terrific outing they've had and talk about it for weeks.

The first real barbecue I had on the roof was comical. All the staff brought in their barbecues. Now Hamilton has a CHML helicopter flying around at 4 p.m. We lit the barbecues and smoke was pouring from the roof ... I'm sure they were ready to call the fire department from the helicopter. We turned on the radio and sure enough we heard 'there's a barbecue being held on one of the rooftops.'

Q. What types of community input do you get?
Mary Ann: We have church groups coming in ... the Senior Citizen Band in Hamilton comes in to entertain the patients ... School groups come in with their performances. Two volunteers entertain at our monthly birthday parties. A couple come in to help with the crafts program... We also call on the V.O.N. occupational therapy department to help us with OT or speech therapy, or Chedoke Hospital to help with rehabilitation. School groups come in and sing a few songs or talk to the patients and visit. The patients really enjoy having young people around ...
Sophie: ... Some of them go out with their families — out for supper during the week or home for the weekend.
Mary Ann: Occasionally patients are alert enough to take responsibility to go out alone — usually these are the patients getting ready to go back into community life.

Q. What about exercise for the patients?
Mary Ann: Every morning there's a whole routine that they go through — hands, arms, legs, breathing ... even patients in wheelchairs are still encouraged to move their legs around and keep their circulation going.

Q. Do all these activities bring everyone together?
Joan: ...I feel that more should be involved. The ones that are more interested or capable go in for the more active participation.

Q. Is there a lot of interaction between patients? Do they really get involved with one another?
Sophie: Oh yes. They'll care for one another. One that is in a wheelchair will call on one that 'floats around,' who acts as a kind of babysitter. And sometimes you'll find that the one in the wheelchair can get quite demanding ... they get so used to someone catering to them. The patients seem to really care for one another once they get to know each other a little better. They feel responsible.

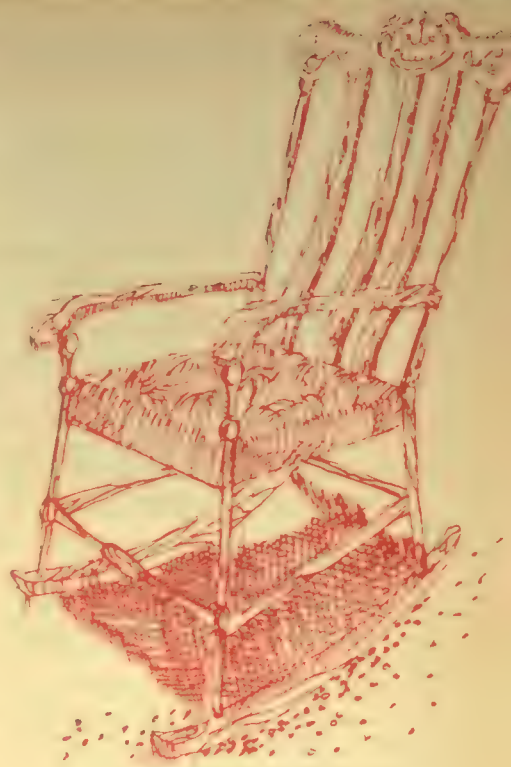
Q. I was wondering if it wouldn't help new residents to get used to the nursing home ... just the fact that there are other people around and everyone is doing things together. Probably part of getting used to the home would be through interaction with the nurses ... knowing that they are cared for. Another part would probably be the other residents. It must be difficult to get into a community after you have lived independently for such a long time. Do the other residents help?
Sophie: Well this sure is a real community in itself. We have several residents who are usually the 'floaters' on the floor ... they know what is going on, and keep an eye out for who's doing what, they know who's going out, when they get back, they notice if they don't see someone in the lounge or the dining room.

If a new patient comes in there is a little time necessary for the older patients to accept the new ones. They wonder where, for example, the new patient will sit in the dining room. I have one patient who will say 'You can't sit there, that chair isn't yours, it belongs to Mrs. So and So.' After a while though, they get friendly, and acceptance comes.
Mary Ann: ... We have two patients who take an afternoon rest together. If I am showing visitors through the home at about 2:30, they sometimes ask if we have two patients to a bed here. The two of them take turns resting in each others' room. They lie side by side and just talk to one another. I've asked them if they would like to share a room but they say 'No that would break up our friendship' but they continue to rest together and are really close.

Q. What about bedtime? Because this is an institution, is there a certain time everybody has to go to bed?
Mary Ann: Oh no, they are free to go to bed when they choose.

Q. That's good for night owls ... What are some of the reactions you get from people when they first arrive here?
Joan: Oh that really varies. Some people are really belligerent — they're not going to have any part of it; some are quiet. Then others just seem to fit in right away as if it was just the natural thing for them.
Mary Ann: Often a patient who accepts the home from the beginning is one ... who has visited the home with the family before. He comes to live here having had some say in where he is going. The patient who wants to get out and feels rejected by his family is one whose family says 'we're going to leave you here for a couple of days' with no explanation. If they say to us 'Don't tell mother that this is a nursing home, we've told her it's a hospital,' we can expect problems. This takes away the patient's rights and responsibilities. Patients with any sense of reality at all need to have a choice in what they are doing with their lives.

Q. It must be tricky for you if the family tells you not to tell mother.
Sophie: You have to let your staff know that the family is keeping the truth from the patient. It's really difficult if you know that the patient is someone who will not return to the community. It's unfair because it takes longer for these people to adjust ... so much longer. The family is also making it so difficult for themselves — they feel guilty to begin with and it's worse because they have to live with this lie.



Q. I suppose that the problem might be that the family feels that their mother can't accept the fact that she is in a nursing home.
Joan: I think the problem is guilt ... and the family just can't face it ...
Mary Ann: The family feels that they are rejecting a family member and they feel so guilty. It takes approximately 6-8 weeks to settle the patient and family. You may have a patient very nicely settled, but the moment the family shows up, the patient gets upset — and it takes a while to settle them again. It happens all the time ... it's a natural reaction and the patient soon grows out of it.

Q. Do relatives generally keep visiting, even if the patient gets upset?
Mary Ann: I tell the relatives very clearly that this is not a drop-off center. Once a patient is admitted, we want to see his relatives visit frequently and if we don't get frequent visits, I tell them that they can expect a phone call.
Sophie: Sometimes we get a situation where we are told that the patient is not to know he is in a nursing home, and many times this patient will get really agitated when his visitors show up. Sometimes then you have to ask the family to stay away for a few days because it's upsetting the patient too much. It always makes me wonder — if they had told the patient the truth from the beginning — would the adjustment be that much easier. I think that probably it would, for both the family and the patient.

Q. Could you tell me about the way a patient adjusts to the home — perhaps a particular patient?

Mary Ann: Something we really like to see ... well, I'll use Mrs. M. as an example. When Mrs. M. came to us, she was a chronic complainer ... very down, not too much going well for her, she wanted to see her doctor constantly. When she was at home, her doctor heard from her daily with complaints. Meeting Mrs. M. now is like meeting a different person — she doesn't use her walker any longer, she is one of the most active people in our programs, both crafts and physio, she always goes to the dining room. Occasionally she'll complain of her leg bothering her, and then say 'well, it's probably the weather'. It's really gratifying to see her accept us and her present life situation.

Sophie: She gets so involved with other patients — she has to know what is going on on the floor. As soon as she finds out, — she's the news messenger — she goes and tells everybody else.

Mary Ann: When she first came, she would hardly ever leave her room, and she constantly complained of her own ill-feelings. Now you can't find a happier, more involved patient.

Q. She sounds like she feels very useful ...

Joan: She really likes to be ...

Mary Ann: At home she was by herself, with her family. All she had to think about was herself, her leg, her arthritis. She couldn't do this and she couldn't do that. The family comments now that they find her so enjoyable to visit.

Q. It sounds as if she feels that this is really her home.

Mary Ann: Oh yes, that goes for other patients too. If they go to the hospital from here, they always say they want to come home, and they mean here; or they will say 'I'm so glad to be home' when they come back. Even visiting relatives on the weekend, they will tell them 'It's time to go home now,' and they mean here.

Q. That's good to hear. So many people tend to think that a nursing home is an awful place, depressing, with so many old people around — maybe that's why families feel so guilty.

Joan: Old people? You know, it's really amusing to see that some 99 year olds around here don't think of themselves as old ...

Sophie: ... and you don't dare call anyone Grandma. They'll say 'Who do you think you're calling Grandma?' They, like anyone else I suppose, don't feel the age they actually are.

Mary Ann: Only one person here likes to be called Gran ....Sometimes patients request you to call them by their first names, but for the most part they like to be called Mr. or Mrs.

Sophie: One patient, Mrs. S. used to be a school marm in England and you just would never call her by her first name. It's respect ...

Joan: When these people were young, first names weren't used as freely as they are now, and it's only respect to call them by their Mr. or Mrs. ....

Q. Mary Ann, what do you go through with families before their relative is admitted to a nursing home?

Mary Ann: I have quite a lengthy discussion with them, explain to them what is available for them in our nursing home, what activities there are. I also try to help them let go — to allow professionals to take over... I try to see how they feel, talk to them and let them know that I am aware of the feelings that they are going through. I try to put them at ease and tell them that if they have any questions at all after they leave that they needn't hesitate to call. Once the relative is admitted to the nursing home, I encourage the family to come and talk to me to ease them through this change. We have some really good relationships with families, when they get to know that they can talk to us. We get to know each other well.

Q. What would you say makes your job interesting and satisfying?

Joan: It's a friendly atmosphere. In contrast to a hospital — to me a hospital is like a factory — the more you can produce the better they like you. Here, I enjoy my work. I laugh a lot. I like the things the patients do and say ... I get so much enjoyment out of just trying to help... doing little things. Some days, I don't seem to do so much ... I do my routine work, but haven't done anything extra, and that frustrates me. But there is always the next day to try again. I just enjoy it — I can't give you any specific reason.

Sophie: I think the personalities of the patients themselves are really interesting. The satisfying part of it is in having patients come in and working with them for a long period of time. Over a long term, if you set a goal for them, you see them progress to a point where they will take the initiative and say 'I am ready to do such and such a thing.' It's great even if they start participating in physiotherapy and loosen up their limbs, or start walking. This is where I find satisfaction ... in seeing a person developing, in taking a part in it.

Mary Ann: We get patients from rehab centers and we will be told ' We have taken this patient as far as he can go ... he will no longer be able to walk ... he is a wheelchair patient ... he will never be able to use his hands, etc. .. When we get them into our nursing home we start activating them again. We work with them and work with them and we never set a short-term goal for the patient, say that he has to attain this goal in six weeks or six months. We take as much time as the patient needs. We have patients now — we were told they would never walk — and they are walking ... because we never set a time limit. We have as much time as they do. For myself, that's where I get great satisfaction ....

Sophie: And yet, we don't have the elaborate physiotherapy equipment that they do in some places ...

Joan: But don't you think it's because it's the same familiar person looking after them all the time ... the same face, the same voice, ... and that helps them ...

Mary Ann: That familiarity helps with reality orientation too. If the patient is confused, we tell him who he is, where he is ... Earlier, we were talking about families who didn't want to tell a relative that he was in a nursing home. It only makes it difficult to orient a patient if you can't tell them that they are in a nursing home. And it makes it difficult for us to build a relationship with the patient too.

Q. I think after visiting the different floors here that I can see a friendly relationship between yourselves and the patients and among the patients themselves. That must be satisfying.

Joan: You do some silly little thing during the day — to other people it's silly — but the patient really thinks a lot of it ...

Sophie: I think the patient gets used to the staff ... to certain people for certain things ... they know the channels of communication ... Here the patients really tune in to you, pick up your moods ... It's really like a family in that respect.

Q. It seems to me that you really enjoy working with the patients here. How do other nurses that you know react when you talk about working in a nursing home?

Joan: They think I'm crazy. They just say ... 'oh, that place ...'

Sophie: ... or, 'How can you stand to work with *all those old people?*'

Joan: I've had a doctor say that to me. Once people know where you work they never seem to ask any more questions ... it seems to end everything as soon as you say where you work.

Mary Ann: Hospital nurses go on and talk about what is going on where they work ... Maybe they think that we have nothing to say.

Q. Maybe it's because our attitudes about getting old are really negative. Nursing in a nursing home seems to be considered a dead end. In hospitals we take so many extreme measures to continue life. No one wants to admit that aging is taking place...

Mary Ann: We've had relatives and doctors ask us, when patients are getting towards the end of their lives... they want them to stay with us, to let them die with friends around, to die with dignity ... It's missing in a hospital ... there's just so much confusion. Here the patients are also quite open. They say they are ready to die — and there are no heroics... It's personal here, no room numbers, no bed numbers, no disease labels. It's more understanding...

Acknowledgement

I would like to thank the nurses at the MacKenzie Nursing Home who took part in what turned out to be a very enjoyable interview: Mary Ann Smith, the Director of Nursing; Sophie Godzisz, who works on the second floor of the home; and Joan Harding, who works part time on all three floors of the nursing home. All are graduates of St. Joseph's Hospital School of Nursing in Hamilton.

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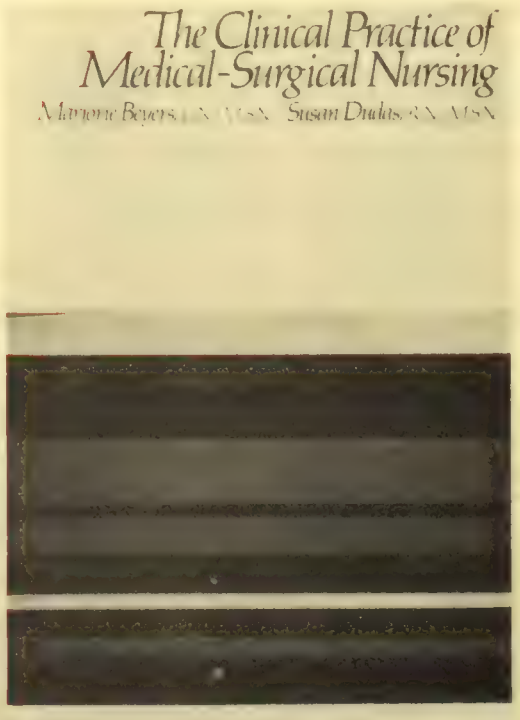
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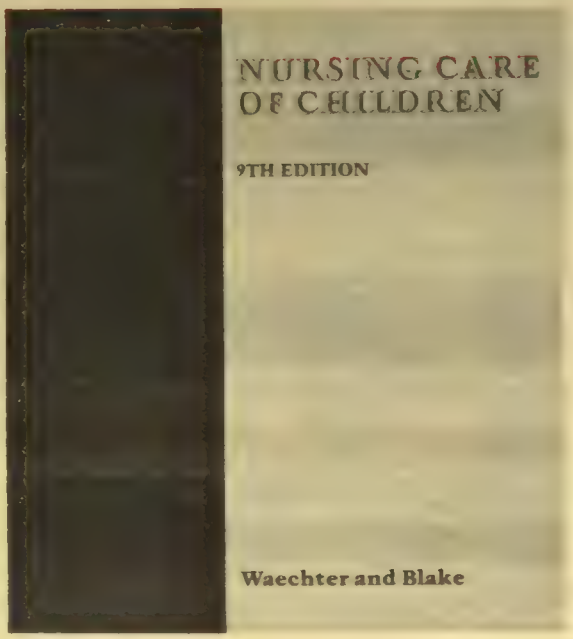
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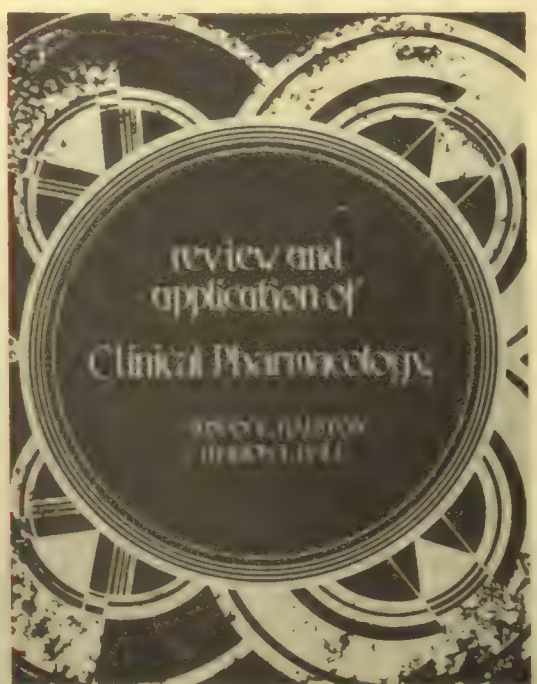
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MAKING THE MOST OF "the golden years"

Mike Grenby

There's free money for the asking when you're a senior citizen — but you've got to ask...

Nurses involved with senior citizens can play a vital and rewarding role in helping these patients to get all the benefits to which they are entitled. After all, financial health (real or imagined) and physical health are often closely interwoven.

While government pension benefits may be regarded as inadequate, what's even worse is not getting those benefits for which somebody does qualify.

Don't take for granted that people know about and are collecting such benefits: all too often they don't know and/or aren't collecting.

To find what's available, contact the local Canada Pension Plan and Old Age Security offices plus any provincial and municipal government departments which offer retirement or low-income benefits.

Some groups and companies have gathered this information. For example, City Savings and Trust Company has published *Dollars and Sense of Retirement*, originally compiled by the Vancouver Resources Board.

It deals with topics like the following — and these apply right across Canada — telling what is available and how to get it:

Veterans' benefits: There are disability pensions and allowances for certain civilians as well as for veterans, widows and dependents. Benevolent funds for veterans also exist.

Canada Pension Plan: In addition to the retirement pension, there are also widow's and widower's pensions and death benefits.

Old Age Security: If one has little or no income, in addition to the old age pension, there is a Guaranteed Income Supplement. And there is a spouse's allowance.

Documents: This is a list of the vital documents needed when one applies for the various benefits — also, what alternate documents will be accepted for proof of age, for example.

Income tax: It's important to know what income is taxable and what is not.

This booklet also provides information on provincial, municipal and community services for seniors.

While this part will be of specific interest only in B.C., it could also be useful



in other provinces: to give an idea of the types of resources which are available.

(Copies — single or in reasonable quantities — of *Dollars and Sense of Retirement* are available free from City Trust, 777 Hornby Street, Vancouver, B.C. V6Z IS4.)

You could also check your local community groups and appropriate government departments to see if anybody has put together a similar booklet for your province or community.

Even if you don't uncover a handy list, the search in itself should help you to compile your own list of services.

This is an invaluable asset: If you cannot help someone yourself, the next best thing is to know where to turn for help or to whom to refer a patient.

Here's a quick rundown of the types of things you might look at, in addition to the points mentioned earlier:

Banking privileges, customer services, housing, health care, help at home, legal services and information, congratulatory messages, action on issues, transportation and travel, senior citizen organizations, learning opportunities, libraries, clubs and centers, immigrant and interpretative services, and volunteer opportunities.

Many services are free or offered at reduced cost to senior citizens — bank services, bus transportation, drugs, movie admission — but again, you have to know about them and know how to get them.

It's extremely important for everyone, but particularly older persons, to have a record of personal and other important financial documents.

There could be pension money building up rather than being paid out, or bond coupons going unclipped, for example.

Many banks, trust companies, credit unions and other financial organizations produce free booklets to help the individual compile such a personal record.

One of the best I've run across is *Knowing*, available free from The Institute of Chartered Life Underwriters, 41 Lesmill Road, Don Mills, Ontario, M3B 2T3.

The first half of its 24 pages deals with personal papers, a household inventory, will executors, being an organ donor, funeral arrangements and knowing whom to contact.

The other half of the booklet contains forms to fill out, detailing the particulars of topics like personal papers, insurance, investments and personal advisers.

To keep control of money, you must know how much is coming in and going out. Only then can you make decisions as to arranging and planning your affairs.

Again, financial institutions produce free budget books. I'd recommend *Your Scotiabank Budget Book*, from the Bank of Nova Scotia.

Find out who handles the patient's financial affairs.

If nobody, look around for a sympathetic, intelligent adviser — somebody you could probably use for your own affairs, too.

Finally, make sure there's a recent will.

Don't take the patient's word for it. Find out who drew up the will and check with that person to see if the will is adequate, given the patient's current situation and outlook.

Especially where there are dependents, it's vital to have a properly drawn will so that the financial as well as the emotional grief following death will be minimized.

If you have any questions on your personal finances — involving investment, insurance, banking, credit or any other such matters — write to me c/o The Canadian Nurse.

While I cannot reply individually, I will answer as many questions as space allows.

Letters must be signed, but only your initials will be used if you so request.

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Frankly Speaking

Aging: The Myth and the



John Duffie

For many older Canadians, life has become a nightmare. There are now three million people in this country 60 years of age or older, and far too many of them are living at or below the poverty level — lonely, demoralized, and frightened by a runaway inflation that is robbing them of the fruits of their life's work.

The economic consequences of aging are only one aspect of the problem. We are now beginning to realize that the emotional and psychological impact of retirement is, if anything, more important. Many of us derive our place in society, our very identity, from our jobs. With retirement, there is a terrible feeling of loneliness, a feeling that we have been cut off from the mainstream and have become a little less than human. One of the most destructive features of our society is the way we equate chronological age with biological and physical age, thus depriving the old of their independent status and their right to use their talents and abilities.

Young people tend to regard the old as obsolete or useless. Dr. R.N. Butler, winner of the 1976 Pulitzer Prize for his book "Why Survive?", coined the word *agism* to describe this negative attitude toward the elderly. He considers agism to be on a par with racism and sexism, and states that in its simplest form it is just "not wanting to have all those ugly old people around."

"All those ugly old people..."

A negative attitude towards old people may be based in part on an underlying fear of growing old ourselves. Our tendency to avoid the word old and substitute euphemisms such as "harvest years" or "golden years" may be a kind of denial of this fear.

Agism is also reinforced by our economic system. In order to keep this system operating, there must be constant growth, ever-increasing production, a high level of consumption, and corresponding waste. Products are designed to wear out quickly or to be superseded by new models. Everything must become obsolete and be discarded quickly, and it follows that the same attitude carries over into the value we place on human beings: the old, labelled useless and non-productive, have no other destiny than the scrap heap.

How do we rationalize our collective and unconscious cruelty? Looking at the image we have of the 'old' we find a stereotype that runs somewhat along these lines:

> *Most old people are sick and confined to institutions. They are unproductive, and unemployable because they miss too much time due to illness, besides being accident prone. Intelligence declines with age, sexual desire and ability disappear, and most elderly people become cranky and disagreeable.*

It's not a pretty picture. How much of it, if any, is true?

Investigating the myth

The fact that about five percent of the elderly population is confined to institutions usually comes as a surprise to most of us. Furthermore, many of our institutionalized elderly are suffering from conditions contracted earlier in life, conditions that are not the result of old age per se.

Are the old unproductive? They may not be prominent in areas requiring physical strength or innovative thought, but in fields calling for knowledge, experience and judgment, there are thousands of people who have made tremendous contributions to others in their later years. We have only to think of people like Picasso, Bertrand Russell, and Golda Meir — people whose quality of achievement has certainly not been limited by age. Artur Rubenstein, one of the greatest pianists of all time, undertook a lengthy tour of one-night stands at 82 years of age that younger musicians have described as "killing."

Studies of industrial workers have shown that production per man-hour is greater among employees over 60 than among those under 20. Also, older workers have better attendance records and suffer fewer disabling injuries; nor do they switch jobs as frequently as their younger counterparts.

The only real cause of unproductivity among the old is the absurd barrier against employment erected by governments, in the selection of the arbitrary age of 65 as the start of what has been called "statutory senility."

The myth of declining intelligence became part of our folklore about a generation ago when investigators drew some doubtful conclusions on the basis of tests they were carrying out. These tests were cross-sectional in nature: identical questions were asked of subjects of different ages at the same time. Invariably, the younger candidates outscored the older. More recent longitudinal studies, testing the same individuals at intervals along their life spans, have shown that the original studies overlooked many important factors:

- older people had received less schooling than the young, what they had received had relied more on memorization than on problem solving.
- the old were more subject to fatigue
- they were generally more cautious, reluctant to blurt out what might turn out to be a wrong answer.
- generation differences were important: a test involving the vocabulary of the space age or of computers naturally favored the young.

To quote Dr. Jack Botwinick of Duke University, "The elements of wisdom and sagacity are not represented in the scientific data and were not given the emphasis they deserve." In other words, there is no space on a punchcard for qualities such as judgment and insight, qualities that develop with experience.

The young and middle-aged share in a belief that the old have no interest in sex. It is a strange paradox that a younger generation that has brought about such a revolutionary change in our sexual attitudes is so puritanical in the way it regards sex on the part of its elders.

Often people refuse to recognize the fact that sexual desire can continue long into later life. It is true that sexual *activity* declines among many of the old, but in most cases this is due to the acceptance of the old age stereotype on the part of the elderly

Reality

Adapted from an article by John Duffie in Victoria's *Monday Magazine* July 28-August, 3, 1975.

themselves. Impotency becomes a self-fulfilling prophecy, and desire disappears.

Proof of the enduring power of sexual feeling can be seen in the fact that, despite a negative attitude on the part of society and the lack of appropriate atmosphere for courtship, marriages among the elderly continue to take place. Dr. Isidore Rubin, in "Sexual Life After Sixty," tells of one home for the aged in which there were 29 marriages in a 21-year period, these marriages proving more durable and congenial than most unions contracted at younger periods.

As to the charge that old people become cranky and disagreeable, — it can be argued that there are just as many disagreeable young people. Cicero, in his essay on Old Age, said: "Old men are said to be peevish and fretful and irascible ... but these are faults of character, not of age." After 2,000 years, his words still ring true. The kind of old person you become depends entirely on the kind of young person you have been, on the kind of person you *are*.

From the Age of Aquarius...

While the 20th century stereotype persists, there are signs of change everywhere. The old are becoming news and after years of total preoccupation with the young, television, magazines, newspapers and radio, are adjusting their sights and beginning to pay attention to the old. There is evidence on all sides that the Age of Aquarius is over and that we may be entering the Age of the Elderly.

The reason for this surge of interest is obvious. The older segment of the population is still growing but the widespread use of birth control devices is reducing the proportion of young people. The statistics are impressive: In 1971 Canada had 2.5 million citizens aged 60 or over, or about 11% of the population. This is expected to rise to 18% by the turn of the century. The United Nations predicts that by the year 2000 there will be 600 million people in the world over 60, and the report adds, "Aging may be one of the crucial policy questions of the last quarter of the 20th century."

A society that stresses "health," is also likely to produce a different breed of old person, more vigorous and alert than every before in history. The "new" old will be the same persons who made up the baby boom of the 1940s, were responsible for the campus confrontations of the 1960s, and who changed our entire moral and ethical standards. Soon after the turn of the century they will be the 60-year-olds, and it is my opinion that it is unlikely that they will accept passively any attempt to consign them to geriatric ghettos.

The potential economic problems may be serious. As the proportion of old people in the population becomes larger , the younger, working group grows smaller with a resultant reduction in the tax-paying base that supports the group at the top. Already rumblings are being heard. A labor spokesman at a conference in Florida suggested recently that the American Constitution be amended to provide for a maximum voting age, so that the voting power of the old might be kept under control.

Aside from the huge sums needed for pensions and welfare, there will be an overwhelming demand for more and better nursing homes, extended care hospitals, more provision for home care, and a growing need for doctors and other medical personnel to be trained in the special needs and problems of the old.

A Sleeping Giant

The basic needs of the old are not unreasonable — freedom from want, affordable housing, the right to share in the community's recreational, educational and medical resources, the right to work for those who want to work and are capable of working and, above all, the right to be useful, respected members of the community, with a voice in the way society is run.

The elderly may be likened to a sleeping giant, just beginning to stir and rub his eyes. They have accumulated experience, wisdom and vision during their many years on earth, and the failure of society to make use of these qualities is a waste of human resources, destructive to the elderly themselves and signifying an enormous loss to the country.

There are difficult, complex problems to be solved, and people of all ages should be working together now to find solutions. Time is running out.

John Duffie, *(Victoria, B.C.) is a member of the American Association of Retired Persons, the National Council on Aging, International Federation on Aging, the B.C. Old Age Pensioners, the Canadian Authors' Association, and numerous other groups. Retired from his position of Property Tax Manager with Canadian Pacific, Duffie has channelled his energies into other areas: "Believing strongly in varied interests for retired persons, I am trying to develop a sort of second career as a free-lance writer, specializing in the field of aging and retirement." His work has appeared in several weekly papers in the Victoria area, and he has had some speaking engagements and a couple of T.V. appearances, all concerned with problems of the elderly.*

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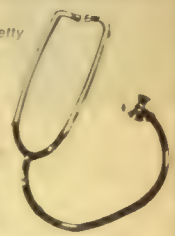
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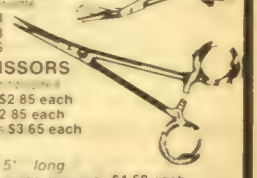
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Living to eat: NUTRITION for SENIOR CITIZENS

Mike Grenby

Here's food for thought for nurses involved in the care and feeding of the elderly:

Seniors (65 and older) appear to be one of the most poorly nourished groups in the country, according to the Nutrition Canada survey.

Senior males in particular seem to be the most vulnerable of any group to nutrient deficits.

The cheerful side of this discovery is that the only way we can go is up.

According to Wendy McDonald, public health nutritionist for the Nova Scotia Department of Public Health, diet in old age appears to be more for maintenance than change.

"As a person ages," she says, "his needs for calories decrease because of both reduced physical activity and decreased cell mass.

"Data collected over the past decade have indicated reductions in weight and height beginning at age 55.

"Active protein tissue is slowly replaced by fat even in a person who is not overweight. At the same time, however, the needs for nutrients do not decrease."

This means that while old people don't need as many calories, they still need their nutrients. In fact, the elderly need just as much protein as the young.

"Also, sufficient roughage and water must be consumed to preserve bowel regularity," Wendy McDonald says.

"Avoid excessive salt to prevent fluid retention and elevation of blood pressure. And reduce intake of saturated fat and cholesterol to prevent arteriosclerosis."

Although there is no clear evidence that aging can be slowed down through nutritional means, the aging process can certainly be made a more pleasant one through adequate nutrition.

"The aged have the highest prevalence rates for illness and disability," Wendy McDonald noted. "Although they represent barely 10 percent of the total population, they account for a far greater percentage of health care dollars.

"The point here is that almost one half of old people's health problems are related to nutrition."

Compounding and often causing nutrition problems are low income, loneliness and lack of incentive to eat, food fads or cultural habits, chronic invalidism and/or lack of mobility, poor dental health and deteriorating or vanished taste buds.

Studies have shown the most commonly neglected foods are cheese, whole grain cereals, citrus fruit, eggs, milk and vegetables and fruit, according to the public health nutritionist.

"Of those living alone, the women tend to eat better than the men, while the men eat better if living with family or relatives," she said.

"As people grow older, they may lose the motivation to apply the knowledge they already have.

"When you try to improve nutrition, you must also try to improve the individual's desire to help himself — as well as providing accurate

"EATS" IN MY FURNISHED ROOM

I *can* have nourishing meals and snacks in my furnished room even though I have
- no stove
- no refrigerator
- and only a little money for food

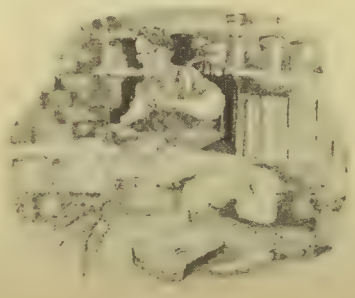
Occasionally I can have a guest, too!

★ **Suggestions for Meals and Snacks**

■ *Breakfast*
Sliced orange or orange sections
Ready-to-eat cereal with milk
Melba toast with peanut butter or cheese
Glass of milk (fresh or dry-skim)
Instant tea or coffee (if the tap water is hot)

■ *Supper*
Salad plate of
— salmon or tuna or cold cuts
— tomato slices or wedges
— green pepper rings
— canned peas or asparagus with lemon juice, salt, pepper, or salad dressing
Milk, tea or coffee
Bread or crackers with cheese
Fruit in season

■ *Bedtime or Afternoon Snack*
Banana milk shake
Molasses milk shake
Fruit and cheese
Crackers and milk
Cereal and milk



* Reprinted with permission of the Vancouver Resources Board.

★ **I keep these foods on my shelf :**

1-2 small cans
— tuna — asparagus
— salmon — carrots & peas
— sardines — green beans
— canned beef — green peas

Vegetables (8 oz. can equals 1 cup)

1 small jar
— peanut butter
— honey or molasses
— salad oil
— vinegar

2-3 wedges of portion-wrapped cheese

1 box or package of dried fruits
— apricots — raisins
— dates — prunes
— figs — shelled nuts
— mixed fruits

They're wonderful snacks !

— evaporated milk
— non-fat dry milk
— tea bags
— instant coffee
— instant cocoa





nutrition information."

And always remember to consider the wide variations in individual nutritional and social needs, she added.

Arlene Tolensky, nutrition consultant with the Vancouver Resources Board, observes that "eating habits we have developed over the years are hard to change. It takes a real effort to modify our food choices to meet energy needs."

Simple substitutions to reduce calories and so avoid the problem of overweight include the use of skim or two-per-cent rather than whole milk, cottage instead of any other sort of cheese, and yoghurt instead of ice cream.

"Portion size is also important. Just because a food is lower in calories doesn't mean you can have twice as much," she warned.

You must be familiar with the basic food groups, which foods are the most nutritious, what substitutions can be made etc. This information is readily available from the health and welfare departments of practically every

1 box or package portion size
- — ready-to-eat cereals
- — Melba toast
- — whole wheat bread
- — rye
- — white or plain

★ **I want fresh fruits and vegetables, too, so:**

I buy one pound of	— apples
	— bananas
	— oranges
	— fruits in season
I buy one-half pound at a time	— tomatoes
	— green peppers
	— grapes
Occasionally I buy a small box of	— strawberries
	— blueberries
	— raspberries

level of government in every province — but you must ask for it.

The B.C. Department of Health, for example, produces *The Senior Chef* with, for example, such basic easy-to-understand advice on buying vegetables as:

"Some vegetables are better buys than others because they contain such a large amount of some vitamins that only a small serving is needed.

"Some examples are carrots, broccoli, spinach, sweet potatoes and squash. Buy small quantities of these often.

"Cabbage has much more vitamin C than lettuce. Serve it often raw as coleslaw. It is much less expensive than lettuce."

Arlene Tolensky also touched on ways to motivate seniors to use information on nutrition.

"If an old person feels lonely or apathetic, he or she isn't going to care much about food," she said. "The idea then is to make eating a social event with other people.

"Loss of appetite can be countered by serving regular meals at regular times, serving hot food hot and cold food cold, including an appetizer before lunch or supper, trying five meals a day instead of three, and so on.

"If chewing is a problem, there are many nutritious soft foods: fish, eggs, cheese, hashes and stews, peanut butter, cooked vegetables, canned fruits, soups, hot cereals, puddings, etc."

Perhaps the nurse's approach to nutrition for the elderly can best be summed up this way:

Try to avoid the philosophy of merely eating to live and encourage as much as possible the idea of living to eat.

Mike Grenby, *author of "Making the Most of the Golden Years" and "Living to Eat: nutrition for senior citizens," both of which appear in this special issue, is on the staff of the Vancouver Sun, lectures and appears regularly on both local and national radio and television, and has done consulting work for the federal government.*

He is the author of a nationally syndicated column that he says he writes "to help ordinary people understand, manage and get the most from their money." His last article in The Canadian Nurse *was a column which appeared in the January issue on income tax tips.*

A graduate of the University of British Columbia and Columbia University Graduate School of Journalism, he is the author of "Mike Grenby's Guide to Fighting Inflation in Canada" (International Self-Counsel Press Ltd.). He and his Australian-born wife, Mandy, who is a nurse, live with their son, Matthew, in West Vancouver.

Suggested Reading List

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NEEDED:
A NEW WAY OF HELPING

For many of our "senior citizens," the decision to enter a residential or care home is not based on medical reasons, but rather on problems arising from social isolation, financial insecurity, or the lack of availability of a "caring person" to help look after them. In Canada, "home help" care workers are almost non-existent compared, for example, to Sweden where more than a quarter of the elderly population receive some form of in-home assistance.[1] Making "home help" more readily available is just one approach to the question of care that is now being studied by a variety of experts at all levels of government.

Richard McAlary

Many observers consider Canada to be less advanced than other Western countries in the care alternatives that it presently offers its elderly citizens. If, as seems inevitable, the number of people over the age of 65 (now estimated at 1,975,000) and the ratio of senior citizens to the rest of the population[2] (currently 8.7 percent of the total)[3] both increase at the rate that is predicted, there is little likelihood of significant improvement in this standard of care unless all of the agencies concerned are prepared to give this problem the attention it deserves. Already, attempts to shift responsibility from one level of government to another, from one agency to another, have begun.



○ **What resources are currently available?**

"Homes for the aged" are now the most frequently used method of providing care for the elderly. Federal-provincial government agreements divide these into five levels or classifications of care:
TYPE I — Often called "personal care" and the most common type of home. These are staffed by non-medical attendants under a medical supervisor.
TYPE II — commonly referred to as "nursing home care," offers intensive personal care using professional nursing supervision.

In 1976, facilities classified Type I or Type II provided a combined total of 134,791 personal care beds in a total of 2,252 homes. This included 48,183 beds in 826 Type II nursing homes.[4]
TYPE III—provides for care of chronically ill patients under 24-hour technical nursing supervision. Generally, these patients must show potential for rehabilitation through a slow-paced program.
TYPE IV — homes providing care for patients and requiring rehabilitation.
TYPE V — acute hospital care.

The most popular alternative to institutionalized health care is *care in the home* and, in countries such as Sweden, this is already a viable alternative. In Canada, Saskatchewan leads the way among the

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provinces in promoting care at home. Instead of continuing to build more special care homes offering Type I and Type II care, the Saskatchewan Department of Social Services is endeavoring to work with the Saskatchewan Housing Corporation (S.H.C.) and the provincial Department of Health to provide a more flexible approach to accommodation combined with personal care services in the form of a Home Care Program.

For senior citizens who wish to remain in their homes, Central Mortgage and Housing Corporation (C.M.H.C.) offers help in upgrading individual homes through the Residential Rehabilitation Assistance Program (R.R.A.P.) which gives partly forgivable loans to families, individuals and landlords who reside in specific sections of most Canadian cities (Neighbourhood Improvement Areas (N.I.P.)) and communities of under 2,500. To date those over the age of 65 have been the largest beneficiaries of this program. The "retrofit" program to assist in the upgrading of homes to conserve energy is also expected to attract many senior citizens.

Since 1967, the federal government, through C.M.H.C., has made loans and contributions of approximately $1.5 billion to senior citizen housing projects of one type or another. Now federal officials have announced that they intend to obtain reassurance that they are providing the type of shelter and aid to the elderly of Canada that is most needed. As a step in this direction, Urban Affairs Minister André Ouellet has called for a dialogue between senior citizens and representatives of the federal government.

Last year, Central Mortgage and Housing Corporation commissioned a study to investigate its role in this area. Among the questions the crown corporation asked itself were:

1. What are the needs and/or demands for health care facilities?
2. What location, design, and operational guidelines for care facilities should C.M.H.C. adopt?
3. What is the relationship between federal funding and provincial health funding in the field of geriatrics?
4. What level of care should the federal housing agency fund, considering it is a "housing agency" not a health care organization?

In the report, Non-Profit Housing for the Aged and Other Special Care Groups by George Hart, Consultant released in the Fall of 1976, he recommended, among other things, that:

- the government take steps to ensure that most of the elderly become financially independent in their own right, especially through a greatly strengthened Canada Pension Plan and flexible retirement.
- C.M.H.C. confer nationally and regionally with social service and health authorities on the timing and force of the new social service program and its implications for housing.
- C.M.H.C. question and propose on the social side of housing as well as legal, financial and architectural aspects: it should not react passively to proposals for certain kinds of unneeded but costly institutions.
- As the new community-based home-helps program takes effect, C.M.H.C. should:

a) continue building self-contained housing, not in too large segregated islands but as small and as well integrated into the community as possible;
b) work with appropriate provincial and municipal authorities to develop sheltered housing adopted perhaps from the British model;
c) fund no more boarding residences as such (without care services or close connection to a care home):
d) fund no more homes providing light personal care only;
e) try to hold down the size of congregate institutions and multi-functional complexes;
f) make suitable exceptions and adaptations in cases of sparse populations, isolated communities, and harsh climate.

- C.M.H.C. continue to capital fund nursing homes providing Type II care.
- C.M.H.C. not classify as health facilities homes receiving support from a provincial health insurance plan because, however they are financed and supervised operationally, they are in fact intensive personal care facilities with nursing supervision.
- C.M.H.C. continue capital funding of care homes where insurance obtains, even though some well-off elderly will pay low fees, because poor to low-moderate income is the present lot of most aged.

Summary

Whatever the outcome of the various government decisions, one thing is certain, a great deal of investigating remains to be done and many important questions remain to be answered. We must find the best way of helping our senior citizens today while, at the same time, remaining flexible in our approach to the changes that will be required in years to come.

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COMMUNITY RESOURCES FOR THE ELDERLY: 2 programs

The number of choices available to an individual, including alternatives for care, seem to diminish dramatically with age, illness, and disability. For many elderly people, maintaining an active life within their own homes or communities, is impossible. Because they need some assistance, they turn to what is offered to them, and in many cases, this means institutionalization.

Here, two authors describe some services which help maintain people in their communities. Both the Day Therapy Centre in Hamilton, Ontario, and the Day Hospital in Edmonton, Alberta offer the elderly person and his family a choice ... both have helped to give the elderly a greater chance to live productive lives in their own homes, their own communities.



Day Hospital

Hazel Schattschneider

CASE STUDY

Mrs. A. *is an 88-year-old lady living in her own home, the home she has lived in for over 50 years. She is a former teacher who had been married for 32 years when her husband died in 1956. They had no children. Mrs. A's brother, now 86 years of age, and sister, now 83 years of age, have lived with her for many years and are now managing the home. They are Mrs. A's principal helpers. They have found the task an increasingly demanding one, particularly when Mrs. A's sister became ill and required surgery last summer. They have been receiving support from the Edmonton Home Care Program for nearly two years, primarily through weekly home help services, and periodic V.O.N. services.*

Mrs. A. came to the attention of the Day Hospital staff when an application was completed requesting short-term holiday nursing home placement for Mrs. A. so that her brother and sister could have a rest. At the time of assessment, it was felt that in addition to short-term relief, Day Hospital support would be most appropriate in assisting this family to continue coping in this situation and in allowing Mrs. A. to continue living in her own home.

On Mrs. A's admission to Day Hospital the following problems were identified and plans made:

- *Unsteadiness with walking and lack of awareness of her right side as a result of a stroke two years earlier. A physiotherapy program of active exercises and assistance with walking encouraging her to walk independently with a walker was planned.*
- *Need for assistance with bathing and personal care. Plans were made for Mrs. A. to have tub baths at Day Hospital. She had been unable to have tub baths at home because of difficulties in getting upstairs to the bathroom.*
- *Arteriosclerosis, and Congestive Heart Failure. She presented with pitting edema of her legs and right arm. Her medications (digoxin and lasix) were reviewed and the dosage adjusted.*
- *Ulcers on her legs. Plans were made for regular observation and dressing of areas.*
- *Moderate confusion. Through involvement in activities, social*

interaction, reinforcement of reality, the stimulation and encouragement provided in the Day Hospital program, it was hoped that Mrs. A. would be motivated and encouraged to increased awareness of reality and increased independence.

- *Family's need for support and assistance with Mrs. A's care. Through Mrs. A's attendance at the Day Hospital twice weekly, her brother and sister are not only given relief from her care but also the reassurance that her needs are being identified and attended to. They are also encouraged to discuss any of their concerns with the Day Hospital staff.*

Now, after attendance at the Day Hospital for nearly three months, Mrs. A. has shown significant improvement in a number of areas.

She is walking more independently with her walker at home. The edema in her arm and legs has decreased markedly. The ulcers on her legs are healing well. She is showing a greater awareness and interest in activities around her. Her brother and sister report that with this support they are able to get a break and are therefore better able to cope with their responsibilities.

It is apparent that Day Hospital is providing significant care and support for this lady and her brother and sister. Plans are to continue in the present plan of care, working towards continued improvement of Mrs. A's health and activity level. Together with the home help services provided by the Edmonton Home Care Program, Day Hospital is at this point contributing significantly to the quality of life for this family and allowing Mrs. A. to remain living at home — the place she prefers to be.



The Edmonton and Rural Auxiliary Hospital and Nursing Home District No. 24 has provided a Day Hospital program for up to 25 individuals per day for the past three years at the Norwood Auxiliary Hospital in Edmonton. The program gives each participant, each with his or her own individual needs, the opportunity to come together with others who have similar problems. As a group, they work together towards a common goal — to become and remain as independent as possible and to continue living in their own homes and communities.

The program began in May 1973 as part of a pilot project of the Alberta Hospital Services Commission. The main goals of the project were:

1. To provide an alternative and more suitable form of care, other than institutional care for handicapped persons, particularly in older age groups.
2. To enable these persons to function more independently in the community.
3. To reduce the costs of providing health services to persons in older age groups."[1]

Plans for the project began in 1971 as the possibilities for the development of such a program were examined. In reviewing the experience of others in implementing a similar program, evaluators found that the "Day Hospital" concept has been utilized in Britian since 1962 in response to a need to release hospital beds and to assist the individual to remain in his own community.[2] Since then, several hospitals in the United States and Canada (including the Maimonides Psychogeriatric Day Hospital in Montreal) have introduced similar programs.[3,4]

Often there is confusion about the terms "day hospital" and "day care center." In the context of the Canadian health care system, it is important to distinguish between these two types of care. A ***Day Hospital*** is a therapeutic setting with professional staff working with patients and families towards a therapeutic goal of reaching and maintaining a maximum level of independence. A ***Day Care Center***, on the other hand, functions in a somewhat different way — providing care and supervision, recreation and social activities but not necessarily by professional medical/nursing staff. In this way, it meets the needs of people who no longer require Day Hospital care but who might require support in a social setting. As well, it provides care and supervision to individuals who are unable to remain at home alone while family members are at work.

Initially, the Alberta program was called a Geriatric Day Hospital. Today, it has widened its scope to include the needs of younger individuals but the program is still primarily geared towards the older person. Those attending the Day Hospital have a variety of medical problems and disabilities; the most common ones are those associated with strokes, diabetes, arthritis, multiple sclerosis, Parkinsonism, arteriosclerosis, organic brain disease and depression.

Planning for the individual patient

At the Norwood Day Hospital, a program of care is planned for each patient. His individual physical, social and emotional needs are considered by the patient care team that includes medical and nursing staff along with the patients themselves, their families and related community agencies. Team conferences are held regularly for assessment and review purposes; family conferences are held on admission and as indicated. Community agencies are encouraged to participate in the patient's plan of care and in its implementation.

Patients attend the program for a period of six hours, one, two or three days a week arriving by 9:00 a.m. and leaving after 3:00 p.m. They travel either by taxi (on a pool basis), the Disabled Transportation System operated by the City of Edmonton or by transportation provided by family or friends.

The Day Hospital staff consists of the coordinator who is a nurse, one staff nurse, one certified nursing aide, one occupational therapy aide, one part-time medical consultant and one part-time clerk typist. As part of a larger complex consisting of an auxiliary hospital and nursing home, the Day Hospital utilizes the physiotherapy, occupational therapy, dietary, housekeeping, laundry and maintenance services of the larger unit.

The services provided in the program include medical and nursing assessment, care and supervision. This would include monitoring of the patients' medical status such as observation of general health status, vital signs, blood tests and other diagnostic procedures and the review and supervision of diet and medication. Teaching the *Activities of Daily Living* is an integral part of the program

as patients are encouraged towards self-responsibility. Patients are assisted with personal care including bathing as necessary. Podiatry and dental services are also available.

Special activities

Physiotherapy and occupational therapy services are available from the auxiliary hospital on an outpatient basis. When indicated, the physiotherapist and the

shuffleboard are demonstrations of the value of such activities. The excitement of planning and anticipating special events such as picnics, teas, Klondike festivities, Day Hospital birthday and Christmas celebrations are high points of excitement and involvement for both patients and staff. Through all these activities, emphasis is placed on the patients' capabilities rather than his disabilities. The patients support each other in the group and as a result, friendships have been established

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their community. Other patients may require care in a nursing home or an auxiliary hospital. The need for some elderly persons to receive continuing care and support in order to remain at home remains apparent.

Since its beginning, the Norwood Day Hospital has grown and developed through the involvement and contributions of patients, family and staff. Besides having been evaluated officially as a pilot project, the program has been evaluated on an ongoing basis by all involved in the experience. While participation in that experience has not been without frustration and occasional discouragement, it has also proved to be most rewarding and we hope that as a result others too may benefit.



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Day Therapy Centre: The Role of The Primary Care Nurse

M. Ann Morlok

Mr. Thomson first attended the Day Therapy Centre at St. Peter's just after the death of his wife. Because of peripheral circulatory problems involving his hands, he had recently resigned his job as a brick layer.

A social worker referred him to the Centre when she saw that his life seemed so meaningless to him, that he was lonely, and very depressed. She thought that some association with others, some involvement in recreational activities at the Centre, might be of help to him.

From his first day at the Centre, Mr. Thomson began to find support from the other men that he talked to. At coffee breaks, he was quick to join in lively discussions about sports, politics, and the 'good old days.'

The occupational therapist discovered that Mr. Thomson was a man of many talents, whose interests included carpentry, mechanics, plumbing and cooking. With the encouragement of the staff and other clients at St. Peter's, life began to fall into place for Mr. Thomson.

The Day Therapy Centre

The Day Therapy Centre is located in Hamilton, Ontario, within St. Peter's Centre, a hospital devoted to the care and rehabilitation of the chronically ill. The programs and organizational structure of the Day Centre are closely affiliated with those of the hospital, so that the clients enrolled in the Day Therapy program can take advantage of the therapeutic benefits of the hospital, as well as taking part in some of the hospital activities.

From its beginning, the geriatric day centre was seen as an active means to ensure the maintenance of the elderly within the community, to encourage the use of as many of their physical and emotional strengths as possible, and to build on their talents, by these means renewing purpose and meaning in their lives. The purposes outlined for the centre are:

- to provide for assessment of the disabled and/or senior person's ability to function at home, with the support of a program focusing mainly on group activity
- to provide continuing support and therapy in order to assist the client to remain in the community, living in his own home setting
- to provide an opportunity for resocialization of the isolated and/or disabled seniors within the community.

In order to become enrolled in the Day Centre, the client is referred by the community, through a family physician, social worker, or community nurse. As soon as he is accepted into the Centre, a program of recreational and therapeutic activities is scheduled by the coordinator and Day Centre staff. The schedule is organized so that the client becomes involved in activities that are interesting and stimulating to him, with the purpose of renewing his feelings of usefulness and worth. Once the appropriate team members have assessed and worked with the client, they compose a problem list to be used as a guide in assisting the client in his rehabilitation.

The staff of the Day Centre, consisting of a coordinator, community planner, social worker, recreation assistant, and myself, a primary care nurse, work very closely with the multidisciplinary hospital team to ensure that the client receives the benefits of the therapeutic resources appropriate to his needs. The hospital team includes a family physician, physiotherapist, occupational therapist, social worker, and recreation worker.

During our association with the client, the Hospital and Day Therapy team functions as a unit, so that each member is cognizant of the others' ideas, plans, management and difficulties encountered. Through the team function, the client is the recipient of shared knowledge and resources.

V.O.N. Input

The role of the nurse within the Day Centre evolved with the program itself. While the program was still in its infancy, it became obvious that this type of setting was an ideal focus for an experimental program of the Hamilton-Dundas Branch of the Victorian Order of Nurses — to explore the greater use of their services in prevention of health deterioration among elderly people living at home.

Many V.O.N. patients have reached some stage of deterioration in their health and many are facing the prospect of a major change in their living style and accommodation. When health breakdown can be prevented or slowed down, the nurse has played a significant role in assisting the senior citizen to remain a part of his family within his own home setting.

Familiar with all facets of nursing within the community setting, the V.O.N. nurse was seen as an ideal person to assume the role of primary care nurse within St. Peter's Geriatric Day Therapy Centre. As a V.O.N. nurse, I was enthusiastic about taking on this new role, a role that expanded quickly.

The Primary Care Nurse

As primary care nurse I function as team leader at an admission conference held after the client has been attending St. Peter's program long enough for all of us on the team to have assessed him. At this conference, treatment plans and goals are discussed with the client and his family. When this conference is completed, a review conference is scheduled for a later date to assess areas of progress and those that need further attention. Hopefully by the time of the review conference, the client will have taken some steps in reaching a greater degree of independence within the community, with less dependence on St. Peter's Centre.

Other facets of the nurse's responsibilities at St. Peter's may perhaps best be illustrated by returning to my discussion of Mr. Thomson:

Mr. T. progressed quickly and took on many activities at St. Peter's. However, with this dramatic increase in his activity, I noted increasing dyspnea on exertion, some bilateral ankle edema, and increasing fatigue. I referred him to his family physician, who in turn directed him to a cardiologist. Mr. Thomson was started on a regime of diuretics and cardiotonics, but the treatment was not very successful.

One day he arrived at the Centre in obvious respiratory distress, with pulmonary congestion and bilateral ankle edema. I contacted his doctor, and he was immediately admitted to the coronary unit of an acute care hospital. With further assessment and management of his cardiac status by the hospital team, he began to show some improvement. While Mr. Thomson was in the hospital, I was able to report pertinent details to the hospital team concerning his home situation, his progress at the Day Centre, and the ease with which nursing care services could be implemented in his home, if necessary, upon his discharge from hospital.

Following three weeks of Home Care management, including V.O.N. and Homemaker services, Mr. T. was able to return to regular attendance at the Day Centre. This time, his treatment program was more successful. During his attendance at the Centre, I was able to monitor important aspects of his medical management: his diet, daily weight, medication compliance, and activity level.

All of us at the Day Centre were pleased to see both physical and mental improvement in Mr. Thomson. We felt even more satisfaction when Mr. T. stated that he had accepted a job offer as a security officer in a downtown office complex. He arranged to see his family physician for his medical opinion and advice, and once he received approval, he began work on a part-time basis. He dropped into the Day Centre when he could, reporting any weight changes, diet and medication compliance and his tolerance of his gradually increased exercise regime.

By the time Mr. Thomson was discharged

from the Day Centre, he had returned to full-time employment with regular health supervision being provided through referral to the Hamilton-Wentworth Health Unit.

One of my important tasks as primary nurse at the Centre lies in assessment of the client's needs. At the time of his admission, I assess the client's health status and his home environment, along with health services available to him. From there, I contact the client's physicians and other services that he may need, and begin to compile a problem list.

As primary nurse, I am also responsible for implementing emergency nursing measures as necessary, and for instructing other staff and volunteers in appropriate response to emergencies. I provide ongoing education to volunteers through organized workshops.

Occasionally assistance with personal care and treatments is provided during the client's attendance at St. Peter's if the facilities for such treatments are not available at home, or if the family situation is not conducive to such care.

Referrals are an important component of my duties. I make referrals to visiting nurse agencies for nursing care in the home, to health units, and/or other allied disciplines for family and client follow-up, especially upon the client's discharge from the program.

When the client has achieved some of the goals worked out between himself and the Day Therapy team, and gained enough independence to function in the community without the Day Therapy Program, I notify his physician of his progress and eventual discharge. Liaison with appropriate community health resources is organized so that the client will have suitable health and social backup.

Education of client's families, staff and volunteers make up a large part of my responsibilities. This may consist of group and/or individual discussion about:

- health problems
- knowledgeable approaches to care
- information about medications
- food and fluid intake
- disabilities and the restrictions that they impose on life-styles.

Patient's advocate

As primary care nurse at the Day Therapy Centre, I have found an opportunity to provide ongoing support to the client and his family in conjunction with the social worker when major changes have to be made, changes such as admission to a nursing home or hospital. I am also in a position to provide data about the client's needs to that admitting institution.

Evaluation of the program is an ongoing process. While I provide input into the activities of the Centre, I also monitor the effect of the program on the client and the benefits derived by his family, and report this information to the team and related medical personnel. I hold a unique liaison position between the Centre and the community on behalf of the client and his family, acting as advocate for both.

The Day Centre is still growing rapidly. All members of the team feel that they play a significant part in assisting the senior citizen to remain very much a part of his own community through the Day Therapy Program.

CASE STUDY

Mr. C. *was originally referred to the Day Therapy Centre for socialization and assessment of his health status. He had no family, and had been assisted by a community social service agency for a number of years. Due to an accident some years ago, and a chronic alcohol problem, Mr. C. had developed a degree of brain damage.*

From my first contact with Mr. C., at the Centre, he looked to me for support when he was frightened, attentiveness when he needed to talk, and a liaison between the community and St. Peter's when life wasn't going very well at home.

I soon found out that Mr. C's home was not all it might have been, and that for him, life wasn't really going well at all. He had a room at the top of a long, bare, winding staircase with no handrails, in a house owned by a young couple who fought regularly.

One day Mr. C. arrived at the Centre crying, shaking and afraid to return home because his landlord had threatened him when he had complained during the most recent battle. It was evident that Mr. C. had to move immediately, and so I made a number of calls to find suitable accommodation for him. His move also meant finding a volunteer to assist Mr. C. to pack his few possessions and drive him to his new 'home.'

Once established in his home, Mr. C. needed help to adjust to the new setting, and to other lodgers under the same roof. Fortunately, his landlady was a kind, understanding person, and although her broken English initially made communication between herself and Mr. C. difficult, there was plenty of good will, something that had been lacking in Mr. C's 'home' until that time.

It didn't take long for the three of us to establish a workable relationship, a relationship that provided the atmosphere for me to do some health teaching. I taught some fundamentals about balanced diet, about more economic food shopping, about the necessity for good body mechanics to avoid back strain. My assessment of their situation led me to direct some of my teaching to these areas. Eventually, gentle persuasion convinced the landlady of the need for more regular medical check-ups, for herself and for her lodgers.

During Mr. C's visits to the Day Centre, I was able to monitor his weight, diet, and vital signs (he had problems with hypertension). Some months after his move, while routinely checking his blood pressure, I suggested that he visit his family doctor for his routine examination. A regular volunteer with our program went with him.

The volunteer came back with the news that a mass was detected in the left side of Mr. C's throat. After a discussion with his family doctor, Mr. C. was referred to an otolaryngologist, and the volunteer took him to this appointment. Mr. C. made 20 visits to the Cancer Clinic for radiation treatments. At this time I kept in touch regularly with Mr. C's family doctor, the Cancer Society, Cancer Clinic, and his social service agency.

During this time, I also took time to explain skin care, dietary precautions, and side effects of radiation to Mr. C. Our discussions took place in his home and at the Day Centre. Mr. C., his landlady, and myself spent a long time talking about cancer. The positive aspect of his early diagnosis seemed to allay some of the worries that Mr. C. and his landlady shared. Our discussions also opened the door to some healthy talks about their attitudes about cancer.

A small informal teaching session also took place among the staff, volunteers, and other clients at the Day Therapy Centre. They were all concerned to know how they could help Mr. C. They learned about pertinent observations that they could make, about how to support Mr. C. Our discussions enabled everyone to express their fears, to talk in an open and positive way, and to receive the information they needed in order to help Mr.C.

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Baycrest Geriatric Centre

A Continuum of Care

Photo story by Suzanne Emond

Keeping the options open and maintaining optimum quality of life is what it's all about at **Baycrest Centre for Geriatric Care** in Toronto. The Centre provides, under the umbrella of one central administration, a continuum of care that ranges from facilities for social and recreational activities for people still living in their own homes, to sub-acute medical care for patients suffering from chronic diseases, and terminal care for those who need it.

For the older person who qualifies for the services the Centre provides, this means that, as his needs change over a period of time, they can be matched and met somewhere within the total concept of the Centre. Until a year ago, this package consisted of:

- **Baycrest Hospital** — a 154-bed chronic care hospital with outpatient facilities, specializing in physical medicine, rehabilitative therapy, audiology, preventive medicine and geriatric research.
- **The Jewish Home for the Aged** — providing accommodation for 375 people (average age: 82.5) for people who can no longer manage in the community due to social, psychological or medical problems.
- **Baycrest Day Care Centre** — providing rehabilitative programs for elderly citizens who cannot participate in other community programs because of physical or mental problems.

In March, 1976, an extra dimension was added to these services in the form of **Baycrest Terrace,** a minimal care institution intended to permit persons over the age of 65 to continue to maintain a large degree of independence in their living arrangements, while providing, at the same time, 24-hour professional nursing supervision and one main meal a day.

Residents, in turn, are expected to accept responsibility for taking their own medications, arranging for laundry and light cleaning of their suites, shopping, etc.

Both residents of the Terrace and senior members of the surrounding community can take part in the activities of **Joseph E. and Minnie Wagman Centre** which is attached to the 11-storey residence. Facilities here include a library, lounge, dining room, convenience stores, beauty and barber shops, and boutique that provides a sales outlet for materials produced in the craft areas of the Centre. The emphasis is on new roles in retirement years and there's a hobby, craft or activity to suit almost everyone's taste, whether he wants to become a photographer, gardener or wood carver. Recreational facilities include a swimming pool, exercise room, billiard and games room.

Linking the Centre even more closely with the community, are two additional services for non-residents — Meals on Wheels cooked in the Centre's main kitchens and a Sheltered Workshop.



"The average stay at Baycrest Hospital is about 91 days — compared to the 1972 Canadian average for chronic hospitals of 246 days. We think that one of the reasons for this, is the fact that we get connected up with our patients very quickly on admission. This means identifying the mental or social problems involved and determining our management of care almost immediately."

"One of the things we've learned is that the nurse needs to understand the healthy aged in terms of normal loss of vision and hearing, the gradual slowing down of gait, circulation, etc. This is a normal process."

"We run Reality Orientation classes for five or six residents half an hour each day. The nurses use boards containing key words and repeat information about time, next meal, last visit, day of the week, etc. They also discuss current events, Jewish holidays, the weather — anything the patient can relate to. The program relieves a lot of the agitation of the impaired aged. Our floor used to be confused and upset — now there's a noticeable improvement in the way residents feel about themselves."

"We help the family to talk with their relatives about death and dying. If they don't, the patient could die alone — in isolation from his family."

"From the standpoint of the welfare and happiness of the elderly residents themselves, as well as the standpoint of benefit to the community, the success of housing for the elderly can be measured largely by the extent to which it helps residents to maintain their independence."

U.S. Department of Housing and Urban
Development, Washington, 1968



"Doctors, social workers, interns, student nurses and nurses all attend our patient care conferences to keep our lines of communication open. This way, the patient doesn't get lost in the language mechanisms of each discipline."

"We believe very firmly that a family has rights and responsibilities too. If we see that a patient has no visitors, the head nurse will call the family to find out what the problem is. If they need help, then our social worker steps in. It's extraordinarily important for patients to have this contact. Having so many visitors, especially children, around makes for a higher noise level but the patients appreciate this as long as it's pleasant noise."

"The patient's family comes in for an interview with the head nurse. We try to put our goals and those of the family together. The atmosphere is completely open: the patient or any member of his family can ask questions at any time and receive an answer."

"We feel that children should maintain their relationship with their grandparents. The patient shouldn't experience another loss, especially while he is sick. Many of our patients have already faced so many losses — their spouse, friends, home, health. They can't lose their family too."

PSYCHODRAMA AND THE DEPRESSED ELDERLY

In the 1930's, Dr. J.L. Moreno, a Viennese psychiatrist, introduced psychodrama to North America. As a young medical student, he had been impressed by the spontaneity of plays enacted by children, and later began to realize that the play medium could be used to help patients resolve their conflicts. For the depressed elderly person — often a forgotten person in our society — psychodrama as an adjunct to individual psychotherapy has been found to be of positive value in helping him to work through frustrations, fears and anxieties and to renew interest in life.



The director (left back corner) encourages the protagonist (center) to act out conflict situations within a supportive group setting. The double (left) moves, acts and feels with the protagonist and if necessary speaks for her.

Dorothy Burwell

"The frustrating frictions of fighting the unavoidable, and the effort to perform tasks beyond our capacity, are the greatest sources of wear and tear. But the stress of using our mind and muscles within the limits of their capacities is healthy, pleasant and indeed indispensable to keeping fit. Man's noblest aim is to express himself as fully as possible according to his own lights. Each of us must find his own innate stress level and live accordingly. Compulsory inactivity may cause more stress than normal activity. When suitably handled, stress can not only produce but also prevent disease." (Marxer, Cowgill).

In the care of the disturbed aging person, there are two major problems to be dealt with — motivation of the elderly person himself, and promotion of attitudes of acceptance on the part of the psychiatric staff. All too often, in desperation, staff resort to argument or advice when talking to the elderly depressed person. This kind of exhortation is seldom effective in motivating the person to change and usually leaves the helper feeling more frustrated and guilty. In turn, this can increase the guilt feelings of the patient, leading to a further loss of self-esteem ... And, thus, the cycle of depression is perpetuated.

For the past thirteen years, I have been engaged in group therapy using the method of psychodrama. This form of group psychotherapy involves a "structured, directed and dramatized acting out of the patient's personal and emotional problems, as well as his social problems, using definable techniques."* It encourages individuals to spontaneously act out their conflicts in life situations, and to release fears, anxieties, and frustrations in the milieu of a supportive group.

For the elderly person who is depressed, for whatever reason — be it loneliness, loss of self-esteem, fear of death — the kind of positive support a group can provide may help him to see his world in a different light and perhaps motivate him to change. Here's how it works ...

In these two case studies psychodrama seems to have benefited two elderly depressed men. Other factors could be considered to have helped these patients but it is my belief that psychodrama provided the initial motivating experiences for both Mr. B. (Uncle J.) and for Horace.

Sixty-two-year old Uncle J., who had been born in Scotland, was a retired wholesale merchant. Enforced retirement was his greatest "frustrating friction" along with "unavoidable" fights with his wife, Aunt S. His depressed behavior was misunderstood by Aunt S. who insisted that he could at least "clean out the garage instead of sitting around and feeling sorry for himself."

In reviewing Uncle J.'s past psychiatric history, we found that he had been first admitted to hospital in 1967 suffering from an anxiety reaction. He had no previous history of psychiatric illness. At that time, he was very worried about his retirement and about his employer giving him the brushoff concerning the possibility of a part-time job. Three years previously, the family had sold the wholesale business to a larger firm. Since then, Uncle J. had been despondent and complained of lack of energy and interest in life. His depression had grown steadily deeper, he became forgetful and had experienced two blackouts in the three months preceding his hospital admission. He also exhibited increasing fatigue at work and tended to fall asleep during business meetings. His speech was slow but clear and coherent when he was given time to carry through a thought.

Treatment consisted of anti-depressants and 7 electro-convulsive therapy (ECT) treatments in one general hospital. Uncle J. was then transferred to the Clarke Institute of Psychiatry, Toronto because the treatment was unsuccessful in relieving his depression.

At the Clarke, both he and Aunt S. were encouraged to join psychodrama — a form of action therapy that encourages individuals to work out the feelings and conflicts they have

* Rubins, Jack L. *Psychodrama. In* Freedman, Alfred M. et al, *Comprehensive textbook of psychiatry.* Wms. & Wilkins Co., 1967, Baltimore, p. 1250.

had with significant others with the help of a director who is also the therapist. The protagonist, in this case Uncle J., is given a "double," another member of the group, who moves, acts and feels with the protagonist for that session and, if necessary, speaks for him in a spontaneous fashion. Other members of the group, called "auxillary egos," enact the roles of the significant others.

Group session A

After a short interview with the protagonist, the director instructs the patient to "show the group" what happened by asking such questions as: "Show us what happened? Where did it take place? What was the room like? Where was your wife sitting?" And the scene begins — a completely spontaneous acting out. In the medium of the group, with spontaneity as the key, and with the assistance of the "double," the protagonist's feelings of anger, frustration, fear, longing, loneliness and confusion can emerge and be shared.

When Mr. and Mrs. B. joined the group of ten patients, they became affectionately known as "Uncle J." and "Aunt S." This pleased Uncle J. who took great pride in demonstrating the kind of high business standards for which he was noted all his life. He went through scene after scene, being able now to tell Aunt S. what he thought about "cleaning out the garage" etc. Aunt S., however, seemed to believe that any activity—even cleaning out the garage would help his state of mind immensely. And after all, hadn't she given up her golf games and bridge games to be with him? Cleaning out the garage was the very least he could do for her in return.

The group soon realized that Aunt S. was far too anxious a person to actively participate in psychodrama, especially when Uncle J. was going downhill. Nonetheless, by using the technique of role reversal Aunt S. tried to see her husband through *his* eyes. As a consequence, she gained just a glimmer of Uncle J.'s predicament.

The closure, the final scene, was about to come — time was running out — and so a 'shot in the dark' was attempted. The "double" spoke: "Well, why the blazes should they put me on the shelf? I'm still young! After all, Mr. L.W., head of that large supermarket, was in diapers when I was in the wholesale business. These young guys owe me something. I built the business up from nothing for them!"

It worked. Uncle J. stopped his pacing during this soliloquy. "You're right — dead on," he shouted at the "double." "How did you know?"

"Come on" said the "double." "I still have work to do! What am I going to do about it?"

"Do about it!" bellowed Uncle J. "I never thought anything could be done ... That is it! I will go and see L. tomorrow."

"What will I say," asked the "double"?

"Cut!" said the director.

This was the time to begin closure. In this final scene the director helps the protagonist and the group to experience positive feelings that give the protagonist the courage to try new patterns of behavior to help release his fears, anxieties and frustrations and to cope with life's crises.

Final Scene or Closure

Director: "Uncle J., you are going to rehearse a scene with L.W. Who could be L.?"

In a few minutes we rehearsed the scene. Of course the group congratulated Uncle J. and supported him with their affection. His self-esteem rose.

The next group meeting was in one week's time. Everyone was on time for this meeting — we wondered what he had done, if anything! Uncle J. told us that he had "girded up his loins," had asked for an interview with L.W., and that the interview had been granted. *Uncle J. reported that he had landed a part-time job!* In a white coat he was to walk up and down the local chain store seeing that the girls on the cash desks were being looked after. A more relaxed Aunt S. was able to go back to her golf and her bridge games. The conflict began to subside.

Therapeutic Effects:

In this instance, psychodrama had numerous effects on the participants:

- The human encounter between
  - — Director/Protagonist
  - — Double/Protagonist
  - — Group/Protagonist
- The assertive training made it possible for Uncle J. to move out on his own.
- The building of self-esteem that followed one successful event.
- The attitudes of patient, group and staff became much more caring and empathetic for this couple — the women supporting Aunt S.; the men supporting Uncle J.
- The space, time element made this more of an experiential learning situation for the patient — feelings long repressed were liberated. Probably one of the greatest benefits of psychodrama is the abreaction — the release of tension and anxiety associated with the emotional reliving of the past, especially repressed events.
- Things went better in uncle J.'s one-to-one therapy.
- Uncle J.'s thinking and speech speeded up.

Group Session B

Mr. Horace M., 66 years old, is another individual who seems to have benefited from psychodrama. Horace, as the group called him, a bachelor, had cared for his mother until her death when he was in his sixties. He was left bereft, and in a depressive state was admitted to the Clarke.

In his group session, we thought it would be best to use a supportive approach to help maintain his defences. But he would not have it — he insisted on a scene with his mother. His grief came flooding forth. His "double," one of the women nurses, simply held him while he sobbed. There was not a dry eye in the group.

What can one use for closure after a scene such as this? The patient is the one to decide. Horace decided that he would like to leave his familiar surroundings for awhile. He had a nephew in Manitoba he thought he would like to visit. We arranged the scene. One of his biggest problems was that of remembering how one purchases a ticket for the train. We went through this scene... and then the trip... as he chugged his way West on the train, porters (nurses) came along and waited on him hand and foot. Their task was to ask Horace to describe the scenery through which they were passing. In his younger days, he had worked in the northern regions of Ontario. When describing the scenery, his impressions became more and more vivid as he reached the head of the Lakes. And finally, Winnipeg! Somehow the nephew drifted off in his world of fantasy and we were back visiting the old buildings of the city and the old cronies who were his friends. We could feel the winds of Portage and Main Street whip around our ankles as he described the "coldest part of Canada they say". We even agreed.

The trip would be called Gestalt Therapy, no doubt, by those who wish to pigeonhole therapies. Moreno, under whom I studied in New York, would say that Gestalt arose out of Psychodrama. Fritz Perls, after all, had studied Psychodrama.

Horace never forgot that session. The group surrounded him. Attitudes of staff and patients change so dramatically towards a more empathetic understanding after such scenes.

The last time that I saw Horace he was in the Clarke Coffee Shop. "Well," he said, " I have just walked three miles. I do it every day now. No, I never got to Winnipeg, but I take my trip around here every day on foot. Sometimes, some young girls join me. We go on sightseeing tours. But now I must leave you, Mrs. Burwell. You see my next group starts in five minutes. It is yoga, but mind you don't tell anyone, I fall asleep in it every time after my walk! But, oh, it is good, Mrs. Burwell." *Horace had come alive!*

Therapeutic Effects:

Again a group of caring persons had surrounded an elderly person in distress. Horace had become the representative of the group and they were able to share their experiences of loneliness following his session. The human encounter helps the patient overcome this isolation that Adler claimed was one of man's greatest fears.

This article by Dorothy Burwell (R.N., M.A) is based on a paper presented at the Annual Meeting of the Psychogeriatric Association of Ontario in September, 1975. Dorothy, a graduate of the Toronto General Hospital School of Nursing, the University of Western Ontario, and Teachers' College, Columbia University, New York, studied psychodrama under Dr. Moreno. A former Director of Nursing and Nursing Education at the Clarke Institute of Psychiatry in Toronto, she is presently Associate Professor, Faculty of Nursing, University of Toronto, and is a Clinical Specialist and Consultant at the Clarke Institute of Psychiatry and at the Sunnybrook Medical Centre, Toronto.

one gentle man...

Bernadette Walsh

The green grass has begun to show through the remaining patches of dirty snow. But the memories are still vivid. It has been some time now — almost three years, since we buried my father, Mr. Finnerty, in the cemetery just over the way. A short walk for us to visit. We brought him home 'to rest' so to speak after sending him away to die. At another time, in another country, he might have died at home among his loved ones. We would have acknowledged his death. We wouldn't have shushed his questions about his impending doom. We would have prayed openly with him and reckoned with him that the chances were slim that he would survive.

From the time of Mr. Finnerty's admission, his prognosis was regarded as poor. He had a history of duodenal ulcers, and the previous month he had been admitted with a perforated gastric wall. He had been operated on successfully and there was no reason to think that the ulcers that had plagued him before would not heal. But he was 74, and the recurrence of melena stools indicated that he was a high risk patient who might not recover so quickly.

He was a co-operative gentle man with a keen wit and a delightful sense of humor. He had a way of making even his doctors forget the seriousness of his diagnosis. He was affable and loved to read the newspapers which kept him up-to-date on all the latest world events.

On the day of his admission, he went to the bathroom and passed almost a quart of blood rectally.

He was transferred immediately to the Intensive Care Unit. It was there that he was to stay for four and a half weeks until he was transferred to a larger center.

It was there that he received the tender care of nurses who grew to love him, of doctors who took exceptional care of him, and of a family who supported him as his body tried to die. He never lost his mental stability. He was constantly aware of the fact that he was bleeding to death. He watched as the nurses and doctors feverishly pumped blood transfusions into him — 30 units in one afternoon alone.

At this time, he and his family agreed to two major operations to stop the bleeding. He came through both of them, alert and aware of what went on about him.

He did not know that his wife and daughter had asked the physicians to turn off the respirator or to stop the blood transfusions, to allow their father to die peacefully. The machine droned on, unable to control a system of perpetuating life which goes beyond all reason. A system dictated by the fear of lawsuits. A system which has been unable to draw the line between life and death. A system which is just now beginning to define death.

If only a veil of confusion had been bestowed upon him so that the things that were happening to him would pass unnoticed. But this gentle man with his quiet sense of dignity would hemmorrhage profusely, and say "just having a weak spell." And when intravenous feedings failed, he would beg for a glass of milk: "Sorry Mr. Finnerty. It will just come back through your levine tube." Soon, however, he wanted nothing for he thought he could have nothing.

It was a mystery to all of us how this man could bleed so much and still rally. He wanted to live. But he would ask "how much does it take to die?" We had no answer. And we never would acknowledge that he might die. "Have faith, Dad," we would say. He had so much faith. I think he wanted too much to believe us, for we wouldn't talk about death. Only living.

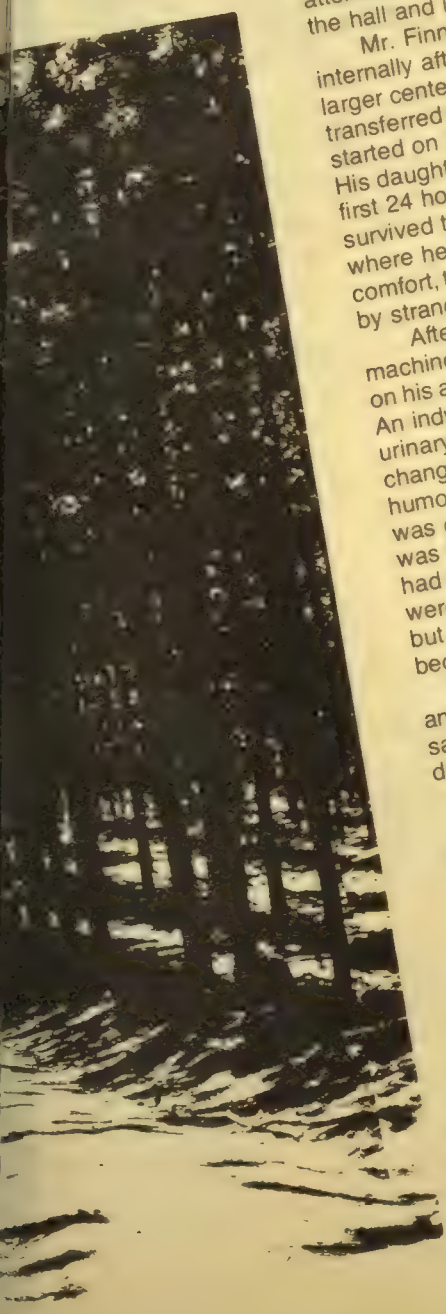
During the third week of April, Mr. Finnerty was transferred to a larger center



Photo by Suzanne Emond



Bernadette Walsh, *Reg. N., author of "One Gentle Man," works part-time in Obstetrics at St. Joseph's Hospital in North Bay and is president of the local Nipissing Chapter of the Registered Nurses Association of Ontario. The mother of four children, she will graduate this Spring from Nipissing University in North Bay with a Bachelor of Arts, majoring in psychology. "One Gentle Man," she says, is one of many stories she has written but is also her first published work.*



in a city 200 miles away. He visited with his grandchildren the night before he left. Somehow, his oldest grandchild, Kevin knew that he would never see him again. He said his goodbys as bravely as any twelve-year-old could. Then he left the room. His shoulders slumped in grief in the hallway when he saw the ambulance attendants move his grandfather down the hall and into the elevator.

Mr. Finnerty continued to bleed internally after he was admitted to the larger center. On the second day he was transferred to the Intensive Care Unit and started on hyperalimentation feedings. His daughter had stayed with him for the first 24 hours and somehow they both survived the transition from the hospital where he had learned to trust and find comfort, to one where he was surrounded by strangers.

After a major hemorrhage, suction machines began to drain the huge fistula on his abdomen that had refused to heal. An indwelling catheter took care of his urinary functions but his disposition changed drastically. He lost his sense of humor and his personal dignity. His body was controlled by external means. He was totally dependent. His family that he had been so close to for so many years were miles away. They came to see him, but the visits exhausted him and he became distant and alien.

Somehow we never allowed him to anticipate death. At one time his daughter said "I think the medical staff are trying to do everything possible to help you Dad."

In his mind, he kept his family close but the barrier was still there created by the determination of the doctors above all else to 'save'. The patient played make-believe, too, an easy thing to do when your life is at stake. Perhaps we should have cried together instead of being brave. We should have said that we would miss each other and talked of old times, memories that only we knew about.

One Wednesday as he was sitting up in the chair, he suffered a stroke. Afterwards, he was unable to speak but was still aware of what went on around him. The next day he had another stroke, and mercifully became oblivious to life. His family were told that there was not much point in travelling to see him: he was unconscious.

Release. His final release. He died on a Sunday. Away from his loved ones. From familiar surroundings. From familiar things. At another time, in another place, he would have died peacefully in the loving embrace of his family. He would have quietly bled to death in the autumn of his life in the environment that was as familiar as his backyard. No levine tubes. No intravenous feedings. No blood transfusions, no surgical intervention. At the age of 74, in the year of '74, Mr. Finnerty died ... alone. In a strange city. Among strangers. No familiar faces of family and loved ones. Of relatives. Of friends. He died away from his wife, his children, and his grandchildren. Away from all the things in life that he loved and cherished. He suffered under the guise of recovery. And the denial of death.

Canadian Nurses Association
Financial Statements
and Auditors' Report

Year ended December 31, 1976

Canadian Nurses Association
Balance Sheet
December 31, 1976

Assets	1976	1975
Current Assets		
Cash in bank	$ 147,592	$ 148,119
Short term deposits plus accrued interest	211,770	536,357
Accounts receivable	44,314	58,824
Membership fees receivable	17,788	12,220
Prepaid expenses	10,968	11,519
	432,432	767,039
Sundry Assets		
Marketable securities — at cost (quoted value $12,314; 1975 $12,868)	4,933	4,065
Loans to member nurses plus accrued interest	10,093	11,289
	15,026	15,354
Fixed Assets — *note I*		
C.N.A. House — land and building — at cost less accumulated depreciation on building	456,199	488,066
Furniture and fixtures — at nominal value	1	1
	456,200	488,067
	$ 903,658	$1,270,460

Liabilities and Surplus		
Current Liabilities		
Accounts payable and accrued liabilities	$ 18,459	$ 39,146
Deferred revenue — subscriptions	35,300	21,900
— other	—	306
Mortgage payable within one year	—	324,534
	53,759	385,886
Grants for Special Projects — *unexpended portion — note 2*	29,945	31,493
Reserve for support to the Northwest Territories		
Registered Nurses Association — *Note 3*	—	11,000
Surplus	819,954	842,081
	$ 903,658	$ 1,270,460

Approved on behalf of the Board:

Joan Gilchrist, *President*

Dr Helen K. Mussallem, *Executive Director*

Canadian Nurses Association
Statement of Income — Testing Service
Year ended December 31, 1976

	1976	1975
Revenue		
Examination fees	$ 649,896	$ 401,534
Interest earned		4,153
	649,896	405,687
Expenditure:		
Salaries	242,230	176,493
Committee meetings	24,192	39,878
Item writing	10,237	23,457
Operations (data processing, printing and warehousing)	89,065	77,740
Consultants	—	5,239
Rent	37,002	28,570
Translation	1,342	5,478
Office supplies and stationery	6,242	8,726
Postage and express	3,040	3,612
Telephone and telegraph	5,160	4,046
Travel — non-committee	3,164	2,496
Equipment maintenance and rental	1,996	884
Books and periodicals	1,226	562
Furniture and fixtures	2,054	10,417
Miscellaneous	40	3,737
Leasehold improvements	—	22,338
Moving expense	—	787
Insurance	420	483
	427,410	414,943
Surplus (Deficit) for year	$222,486	$(9,256)

Auditors' Report

To the members of Canadian Nurses Association

We have examined the balance sheet of Canadian Nurses Association as at December 31, 1976 and the statement of income and surplus for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests and other procedures as we considered necessary in the circumstances.

In our opinion these financial statements present fairly the financial position of the Association as at December 31, 1976 and the results of its operations for the year then ended in accordance with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Geo. A. Welch & Company,
Chartered Accountants.

January 20, 1977

Canadian Nurses Association
Notes to Financial Statements
December 31, 1976

1. Fixed Assets

It is the policy of the Association to expense purchases of furniture and fixtures in the year of purchase. The C.N.A. House is being depreciated over 20 years at the rate of 5% per annum.

2. Grants for Special Projects

The Department of Health and Welfare and the Canadian International Development Agency advances funds to the Association in respect of grants for special projects. The unexpended portion of these grants at December 31, 1976 totalled $29,945.

3. Special Reserve

In 1974 a special reserve of $15,000 was established for support to the Northwest Territories Registered Nurses Association. In 1975 a payment of $4,000 was made to the Association and the balance of $11,000 was disbursed to them in 1976.

4. Retirement Income Plan

During 1975 changes were made to the Association's retirement plan resulting in additional benefits for past service. Actuaries have estimated that an annual amount of $38,500 for the next 14 years will be required to fund the past service benefits.

Canadian Nurses Association
Statement of Income and Surplus
Year ended December 31, 1976

	1976	1975
Revenue		
Membership fees	$ 1,014,066	$ 955,238
Subscriptions	39,196	38,922
Advertising	306,952	339,604
Sundry income	4,923	7,196
	1,365,137	1,340,960
Expenditures		
Operating expenses:		
Salaries	796,680	759,924
Printing and publications	292,735	245,436
Design and graphics	23,835	14,399
Postage on journal	126,601	118,773
Computer service	45,835	44,894
Committee travel	25,247	36,272
Commission on advertising sales	39,117	33,546
Affiliation fees — I.C.N.	96,175	65,707
— Canadian Council on Hospital Accreditation	6,000	5,000
Professional services	24,762	14,121
Travel — non-committee	15,566	22,347
Office expense	36,690	36,614
Books and periodicals	9,820	10,238
Legal and audit	7,950	5,200
Building services	77,838	88,398
Sundry	6,052	13,725
Furniture and fixtures	1,387	2,954
Property improvements	6,900	189
Depreciation — C.N.A. House	31,867	31,867
Insurance	2,043	6,295
General meeting	—	1,661
Contingency for special projects	1,177	303
	1,674,277	1,557,863
Non-operating expenses		
1976 convention	(13,680)	—
	1,660,597	1,557,863
Surplus (Deficit) for year before items below	(295,460)	(216,903)
C.N.A. Testing Service — per statement	222,486	(9,256)
Investment income	50,847	61,423
Surplus (Deficit) for year	(22,127)	(164,736)
Surplus at beginning of year	842,081	1,006,817
Surplus at end of year	$ 819,954	$ 842,081

Names and Faces



Barbara Ellemers of Regina has been appointed to the position of Executive Director of the Saskatchewan Registered Nurses Association to be effective March 1, 1977. Born in Midale, Saskatchewan, she is a graduate of the Regina General Hospital School of Nursing and has a Diploma in Public Health Nursing from the University of Saskatchewan, a Bachelor of Nursing degree from McGill University, a Post Graduate Diploma in Educational Administration and a Master of Education degree from the University of Saskatchewan. She also holds a Professional A Teaching Certificate from the Saskatchewan Department of Education.

She has had experience in various fields of nursing: primary nursing in hospitals, V.O.N. and public health agencies, teaching experience in both diploma and baccalaureate nursing programs, as well as consultative and administrative experience. Ellemers has held the position of Assistant Superintendent of Nursing Education, Saskatchewan Department of Education 1966-68, during which time she was involved in the phasing out of hospital schools of nursing and the phasing in of nursing education into post secondary institutions under the Department of Education. In the position of Program Consultant in Health Sciences, Department of Education 1970-72, one of her concerns was the nursing assistant program. She was chairman of the committee which designed a bridging program for nursing assistants desiring to continue their studies towards an R.N. From 1973-77 Ellemers has been Director of Public Health Nursing for the City of Regina Health Department. This past year, she has also been involved in teaching as a sessional lecturer on the Regina campus for the College of Nursing, University of Saskatchewan.

The SRNA Council is pleased to announce the appointment of **Marie Lammer** (B.Sc.N., Queen's University) to the position of communications officer of the Saskatchewan Registered Nurses' Association effective January, 1977. Her duties will involve communications with the membership and interpretation of nursing to the public.

Lammer has been employed as a Public Health Nurse I and II in Saskatchewan and has taught in schools of nursing in the province. Her most recent appointment was that of a nursing instructor in communication skills in the Health Sciences programs at Wascana Institute of Applied Arts and Sciences in Regina.

Carole Elliott has joined the staff of the Registered Nurses Association of Ontario as communications officer. She has been in the public relations field for seven years, most recently as public relations officer for Alcan Canada Products Ltd., Toronto. She holds a certificate of accreditation in public relations (A.P.R.) and is a director and treasurer of the Toronto Chapter of the Canadian Public Relations Society, Inc.

Margaret Risk (R.N., Toronto Western Hospital; B.Sc.N., M. Sc.N. in Community Health Nursing, University of Toronto) was appointed assistant director-practice in the Nursing Division, Registered Nurses Association of Ontario, effective February 1st. She brings to this position a varied background with a particular focus on community nursing. Her interest in practice and in the provision of a high quality network of nursing services will contribute to the forwarding of goals set by the profession.

Official Notice

Annual General Meeting of the Canadian Nurses Foundation

In accordance with By-law Section 36, notice is given of an annual general meeting to be held Friday, 6 May 1977, commencing 14:00 hours at CNA House, 50 The Driveway in Ottawa, Ontario. The purpose of the meeting is to receive and consider the income and expenditure account, balance sheet, and annual reports.

All members of the Canadian Nurses Foundation are eligible to attend and participate in the annual general meeting.

Helen K. Mussallem, *Secretary - Treasurer, Canadian Nurses Foundation.*

Assistant Director of Nursing

Applications are invited for the position of Assistant Director of Nursing at the Kirkland and District Hospital, a 138 bed fully accredited hospital.

Duties will include In-service education and the development and implementation of nursing-related policies and procedures.

Applicant should have a baccalaureate degree in nursing and a minimum of three years administrative experience.

Excellent salary and fringe benefits.

Please direct correspondence to:-

Director of Personnel
Kirkland and District Hospital
145 Government Road East
Kirkland Lake, Ontario
P2N 1R2

Library Update

Publications recently received in the Canadian Nurses' Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

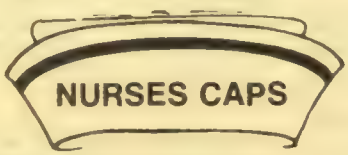
Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

1. Abel-Smith, Brian. *Value for money in health services: a comparative study.* London, Heinemann, c1976. 230p.
2. *Aging and communication,* edited by Herbert J. Oyer and E. Jane Oyer. Baltimore, Md., University Park Pr., c1976. 302p.
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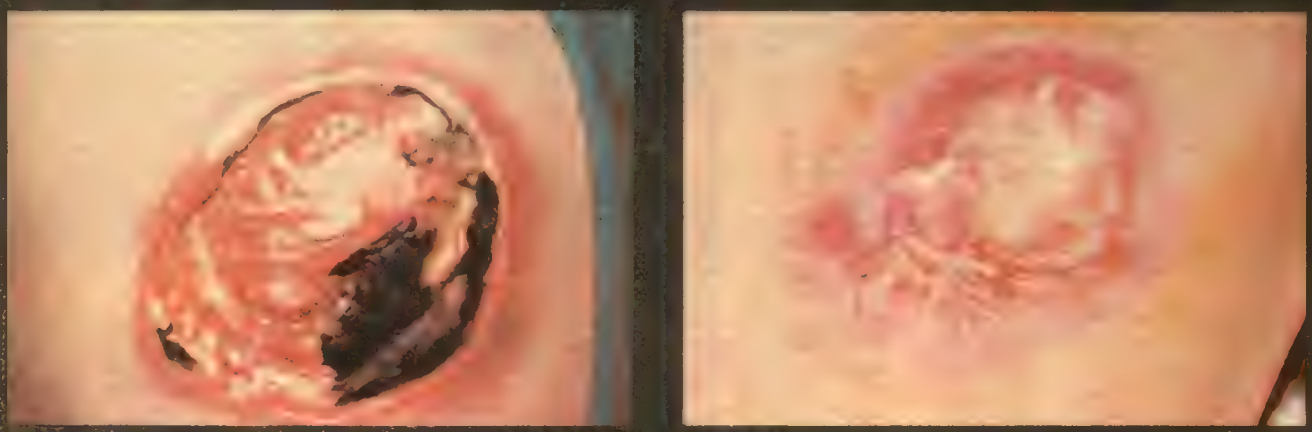
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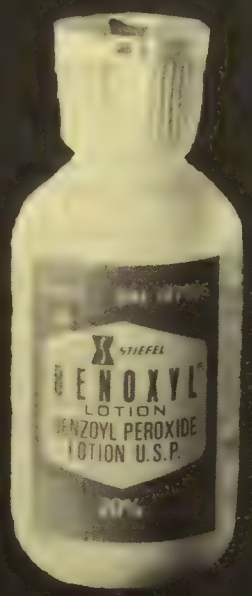


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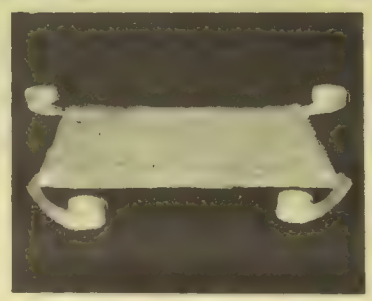
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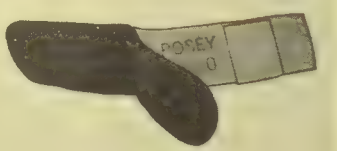
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May, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Cover photo — for 8,000 elementary school children, the highlight of National Safety Week (May 23-29) this year will be a visit to the nation's capital to attend the 18th annual School Patrol Jamboree. The Jamboree is a yearly event staged by the Canadian Automobile Association in recognition of the contribution that these children make to the health and safety of their friends and classmates.

In Ottawa, Constable André R. Boucher coordinates the activities of fellow members of the Ottawa Police Force who supervise school patrol activities. On the cover, Const. Boucher with a group of patrols from a school located near CNA House. (Photo by Studio Impact).

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

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Input

An open letter to M.E. Murray, author of **"The Quality of Our Caring,"** *(March 1977)*

It makes me sad to read your letter. Really sad. I wish there were some way to apologize for your being treated as though you are not a human being. More and more I believe that patients should be asked what needs they have, what suggestions they have, whether they understand their treatment and agree with it. Regarding your illness you *are* the most important person to consider. We nurses should consider your feelings at every moment so as not to add to your suffering.

I have two things I would ask of you. Please show your letter to the nurses where you go for treatment. I think the directors of nursing should see it. The second thing is, please send it to the Canadian Medical Association Journal. On second thought, never mind; I will. Thank you for writing to us.

— Nora Briant, Fredericton, N.B.

A long way from home

I have received my *Canadian Nurse* for the months of January and February. I enjoy reading your articles because it keeps me in touch with home, Canada. I will be looking forward to receiving my next month's issue. Thank you.

— Domenica Formica, New Orleans, La.

Fight for life

I wish to say how sad it is to see that such services as "abortion counselling" (January, 1977), are necessary in our society. We should rarely need such services if abortions were only done for "therapeutic" reasons.

Reactive depression in pregnancy is the reason given for 95% of abortions authorized by hospital therapeutic abortion committees. And yet, it is seldom that in any normal, healthy pregnancy the woman doesn't experience depression at some time.

Where do we place our concern and value for human life, be it ever so tiny? We as nurses are to fight for "life", not help to destroy it.

—Helen Stang, R.N., Macklin, Sask.

A chance to share

Since the summer of 1975 great strides have been taken toward the development of MATCH — International Centre. This is a fledgling organization created to provide a direct link for action in social development projects between Third World women and Canadians. The organization exists to supplement current governmental and non-governmental programs designed to promote the effective involvement of women.

To date MATCH has received some "seed" money from UNESCO, another donation from a women's group and a commitment for matching funds from CIDA. The magnitude of funding from CIDA will be determined by the amount of money and personal involvement MATCH can attract. Realization of the MATCH program will rely on the procurement of funds but an even greater reliance will be placed on the availability of the skills, talents and experience of Canadian women for international development.

Through your journal, I would earnestly appeal to readers to advise of their interest in participating in the program. At the same time I urge readers to make a financial commitment. A major portion of our financial requirements would be met if each one would send a dollar bill to MATCH.

— Jane E. Henderson, Executive Director, MATCH — International Centre, 204A 151 Slater, Ottawa, Ontario, K1P 5H3.

Father's view

Regarding the December article by John B. Allan, "Difficult Babies," it would seem to me, that the most devastating blow to any mother-child relationship, is the standard maternity ward procedure. There is a general policy of separating mother and newborn, while other specific policies add to the detrimental effect on the relationship. For example, application of silver nitrate to the infant's eyes, frustrates eye contact at birth. The wide use of analgesics limits both mother and child in all their responses to each other. Not allowing the child to suckle at birth and administration of bottles in nurseries, weakens the sucking response.

The studies of Klais and Kennell ("Maternal Infant Bonding") clearly show the need for mother and child to be together in the hours and days after birth.

It seems, when our whole way of birth alienates mother and child (not to mention fathers, brothers and sisters), to send out a Public Health Nurse to undo the damage, and call it "Prevention" is quite irrational.

— R.G. Thaddous, Father, Vancouver, B.C.

Feeding is for mothers

The cover on your February issue enhances the common belief that breast-feeding is a rather unusual activity! Yes! Let Father be a part of a "shared birthing," let him be comfortable and knowledgeable in the handling of the baby but let's leave baby's feeding to mother! As nurses we must help them understand how natural and beneficial breast-feeding is.

The February cover looks like free advertising for those unecomonical nursers that, when discarded, contribute to pollution. I protest!

— Lois B. Hord, B.A., R.N., St. Andrews, N.B.

A father's place

Maternity nursing staffs appear to be bending over backwards, to the point of being ridiculous, in attempting to correct the so-called error of excluding fathers from labor and delivery of their child (February, 1977). No, I am not against fathers being allowed to give their support when it is agreeable to them but I do believe that many parents are subjected to unnecessary embarrassment by the prevailing free-for-all attitude exising today. Small wonder most mothers have cause to say, "You surely lose your modesty when you have a baby!", but why should they? Clinical assessments, which can usually be done in a matter-of-fact manner to reduce embarrassment, are being turned into emotional circus-type spectacles.

I am a midwife and, having practiced domiciliary midwifery, midwifery in a primitive country, and hospital maternity nursing, I am not at all enchanted with the modern concepts of "birthing."

— Name withheld, Stettler, Alta.

Bravo for involving the father in the care of the infant! But why must he be bottling the baby? Changing the diapers, playing with the baby or rocking him would be lovely. The pictures inside were gems. Surely a more appropriate cover picture could be chosen for a magazine aimed at professionals who should know that breast-feeding is the superior way of feeding an infant.

— Susan J. Lawrance, Philadelphia, Pa.

A difficult decision

I read with interest the article "Peter — an infant with a myelomeningocele," (January, 1977) but I also felt some distress when I finished the article. Why? Because nowhere in the article was mention made of someone having spoken with both parents to tell them about the condition, prognosis and probable future of their child so that they could decide with the doctors their child's future.

In April, 1976 I gave birth to a "Peter" but I was fortunate in having a very understanding pediatrician who saw me in the delivery room. The three of us decided, after much discussion, on no treatment and our wee one died a little while later. Perhaps my training at the Hospital for Sick Children made my decision a little bit easier.

While talking with the pediatrician he mentioned that doctors here in Melbourne are now questioning whether they've been right to rush in and do surgery and then leave the parents to cope with an invalid child who may also be retarded.

If the parents wish surgery knowing the pros and cons then so be it but I feel strongly that they should be given some understanding of what lies ahead for them AND their child before surgery proceeds.

— J. Grant, Brighton, Vic. Australia.

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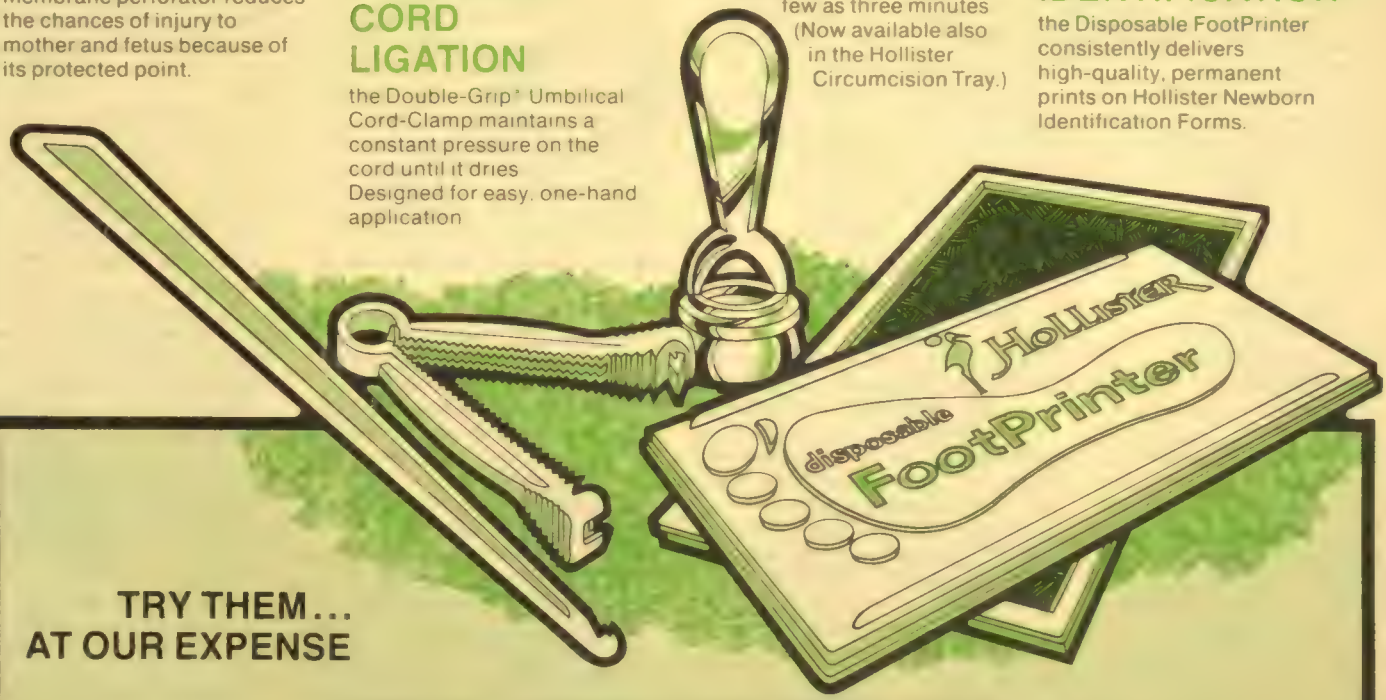
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Input

Call for help

The Gander & District Home Care Program, (Newfoundland) which is now in the planning stages is having problems ordering equipment adaptable for use in the home.

We have been unable to find

- companies which supply bed rails for non-hospital beds;
- safety toilet frames that can easily be removed from the toilet when the patient no longer requires them;
- bath tub grip rails that clamp onto the edge of the bath tub;
- some sort of monkey bars that can be set up at home.

Maybe some of your readers have suggestions about making their own home care equipment or improvising equipment that is readily available. We would appreciate any help that anyone could give us.

— Sandra Kelly, Home Care Nurse Co-ordinator, James Paton Memorial Hospital, Gander, Nfld. A1V 1P7

"Difficult Babies" —Cerebral Palsy?

The article "Difficult Babies," (December, 1976) was drawn to my attention by the Assistant Director of Nursing of the Edmonton Health Department.

After reviewing the article I thought it worthwhile to point out that the term "difficult baby" as used by Dr. Allan would certainly encompass many infants who exhibit one or more features of cerebral palsy. Identification of infants with cerebral palsy is of major importance. Therefore it is mandatory that any infant with "disturbances in the five major reflexive behaviours" as outlined by Dr. Allan, be assessed by a pediatrician, following which intervention by a trained occupational therapist and/or physiotherapist might well be necessary.

The five behaviors designated as characteristic of the "difficult baby" may well lead to difficulty in maternal-infant bonding. However, the reason for appearance of the type of behavior described may be due to central nervous system damage. Identification of neurological abnormality is essential, e.g.:

1. A problem with sucking or a poor or weak smiling response may be due to poor control over facial muscle movement because of neurological abnormality.
2. Eye contact may be poor due to problems with ocular alignment or difficulties with control of fine muscle movements of the eye.
3. An infant may be rigid due to excessive extensor tone due to neurological damage. It is important that mothers of such infants are not taught to support the back of the child's head as this reinforces the tendency to extension. Of course advice regarding handling of a rigid, irritable infant should be sought from medically trained persons.
4. The passive, limp or hypotonic baby may exhibit these characteristics as a consequence of neurological damage. Specific programs for such infants should be developed by a physiotherapist and/or an occupational therapist in conjunction with a pediatrician.

The public health nurse is indeed in a position to advise parents regarding methods of enhancing the maternal-infant relationship. However an infant exhibiting any of the characteristics described in the article "Difficult Babies" should be examined by a pediatrician. Children exhibiting the behaviors described in this article will need continued medical supervision and, in addition, many will require therapy by an occupational therapist and/or physiotherapist.

— R. Brenda Schmidt, M.D., F.R.C.P.(C), Community Pediatrician, Edmonton, Alberta.

Under alien flag

When my March issue of *The Canadian Nurse* arrived, the "richness" of the cover held my attention longer than usual. Never before, except on the chest of an old general, had I seen such a display of honors!

Even more gratifying was the sight of that familiar badge in the upper left-hand corner, the one reserved for graduates of Saint Sacrement Hospital in Quebec City — a red cross bracketed by laurel leaves and, on the mini coat-of-arms at the bottom, the three letters "HSS". But this is not how it was identified on page 4!

Suddenly, I could see my colleagues and instructors, and I thought of all the others who would have wanted to sign this letter with me.

— Jocelyne Dionne,(HSS, 1962-1965) Quebec City, Quebec.

Editor's note: Our reader is absolutely correct. The pin is from Saint Sacrement Hospital and was presented to the CNA Archives by Michele Kilburn, former CNA director of information services.

Strength in numbers

The comments of one of your readers (Krmpotich, Input, February) on public health nursing are worth commenting on... I agree that not enough preventive nursing is done. Doctors are often more interested in people who are sick. They say they do not have time for prevention because of the pressure of work. Medical students are more interested in the drama of surgery and medicine than prevention which often produces no visible results.

Why are doctors not paid a salary by the provincial governments instead of an amount determined by the number of patients seen and conditions treated? Imagine nurses filling in cards so that they can get paid for each bath, medication given, bed made, baby weighed, etc!

Governments concentrate on acute conditions. That, Mrs. Krmpotich, is one of the reasons that public health nursing services are underutilized. That is why there are no midwives in Canada who can advise during the prenatal, delivery and post partum periods.

People can often relate better to a nurse than to a young doctor with much theoretical knowledge but little practical skill in solving problems of daily living. Most doctors are from the upper socio-economic classes. I do not know of any study on this regarding nurses, but I should imagine that not many are from the upper classes. In the past, the upper social classes have been the ones to make the rules for the country, and this is how the doctors obtained their status and rights.

Nurses have only recently begun to unite for their rights and conditions of employment. Nurses need to understand the duties of their fellow nurses, and be able to show the medical profession, by words and actions, that they are capable of being members of the health team.

So often one hears disagreements in the hospital — between the nurses on different shifts for example. Very unprofessional. One does not hear disagreements between doctors aired in public places. There should be a liaison between the nurses in the different hospital units, and those in the community. Nursing cannot be strong until it is united — a divided profession falls.

Doctors have the advantage of being able to follow the patient through all of his health problems. Public health nurses have some of this advantage as they get to know the whole family and so can provide the doctors and hospital staff with much information.

A liaison, with willingness to learn about the work of others, is needed by all the members of the health team, especially in these days of specialization. Not until all members of the health team are treated as equals not just in words, but also in monetary areas, and work as team members, will each area be used to its full capacity. We should all be interested in the health of everyone in the community.

— Pearl Herbert, R.N., S.C.M.,P.H.N.,B.N., Halifax, N.S.

Nothing new under the sun

One of our nursing problems is our own nurses. We do not know what each other is doing. Mohammed Rajabally in his letter on "Social Preventive Nursing" describes a proposed "new avenue" for nurses. This "new" field is, in fact, the present Public Health Nursing service as I know it.

As a Public Health Nurse, I am trying to interpret my services to the public, to politicians and to other health workers, as well as to other nurses. If Rajabally wishes further details about my nursing role, I would be happy to answer any questions.

— Mara Foster, R.N., B.Sc.N., Toronto, Ontario.

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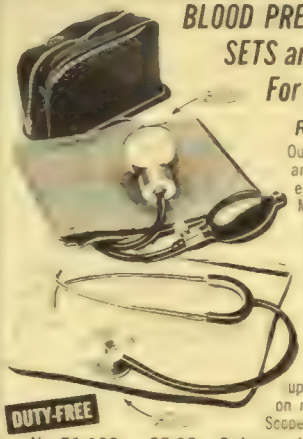
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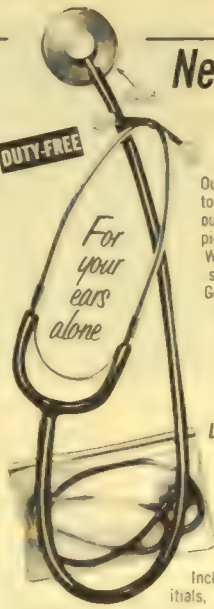
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News

1977 CNA Annual Meeting

Nurses from Yellowknife to St. John and a score or more of places in between gathered in Ottawa's venerable Chateau Laurier Hotel on March 31 of this year to stage the annual meeting of their professional organization — the Canadian Nurses Association.

A total of 81 voting delegates, representing each of the eleven provincial/territorial member associations, were in attendance for the one-day business meeting. Annual meetings take place on alternate years when no CNA convention is being held. The last biennial meeting was in Halifax in 1976; the next is scheduled for Toronto in June, 1978.

Highlights of the lengthy agenda included: the presidential address (for excerpts, see this month's guest editorial); the report of the executive director (see page 11); treasurer's report (see highlights of CNA Board of Directors meeting); report of the CNA Committee on Testing Service (see page 11); and voting on four resolutions (see page 12).

In addition, delegates heard from two distinguished speakers in the fields of economics and law: William E. Haviland, secretary of the Economic Council of Canada, and the Hon. Justice Antonio Lamer, chairman of the Law Reform Commission of Canada. Adding interest to the day's proceedings, was a panel discussion on "Critical Issues in Nursing" presented by CNA's four members-at-large, under the chairmanship of CNA second vice-president, Sheila O'Neill.

Finding an acceptable definition of death is primarily a moral and philosophical problem rather than a medical issue, according to the chairman of the **Law Reform Commission** of Canada.

Justice Antonio Lamer luncheon speaker at the CNA annual meeting, called on members of the national nursing association to help the commission in its task of defining death, euthanasia, meaningful life and lives worth saving.

The Law Reform Commission has recently entered into a "protection of life" three-year research project which will deal with euthanasia, a definition of death, human experimentation, behavior modification and control.

"This is a project which touches on interests and concerns which many of you nurses face, worry about, and cope with — on a regular, even a daily basis," the chairman said. "I am telling you about it because I hope that you and your association will help the commission with it."

He said that contributions by nurses to the Law Reform Commission's project on the protection of life would be considered invaluable because "we are fully aware that nurses are the segment of the medical profession closest of all to the sick and dying."

Law reform is necessary because judges and juries are concluding that the law as it now applies to many acts of euthanasia is outmoded and judicial decisions are made by getting around the law, he said.

"Great uncertainties will remain as long as the law says one thing and judges and juries do other things by their decisions. Medical professionals will continue to be undertain where they stand with the law if they undertake some treatments or omit others. The public won't be sure that its rights and its wishes are protected or likely to be respected," Justice Lamer explained.

Future increases in health care spending must be tied to increases in the economy, according to the **Secretary of the Economic Council of Canada. William Haviland** warned nurses attending the CNA annual meeting that governments cannot support further increases in health care spending. Since World War II, health care expenditures have been rising at an annual rate of over 11 percent, and have now reached about $12 billion a year, or about $520 per Canadian. He noted that much of the increase has occurred in hospital costs due to improved methods of treatment, and inflation.



According to Dr. Haviland, this situation has reflected a general trend in western countries, countries that have relied increasingly on government intervention as a means of improving social welfare and justice. In Canada, health care spending now accounts for six and a half percent of Gross National Product, which is above the average of some 20 industrial countries, but does not exceed the United States. But, he adds, total health care expenditures have been *rising faster in Canada than in the U.S.*

Dr. Haviland recalled that the Economic Council had voiced its concern about this trend six and a half years ago in its *Seventh Annual Review.* It pointed out that an increasingly large proportion of national resources were going into health care activities. At that time, the Council cautioned that this situation was unsustainable. However, only recently has there been widespread questioning of social policies in general and of the concomitant government intervention and regulation.

In light of these new doubts, the Council's forthcoming *Fourteenth Annual Review* to be published later this year, will be devoted to a review of the role of government in Canada. Among the programs to be studied, is the system of medicare, which comprises roughly three-quarters of health care spending. Dr. Haviland noted that an important question to be answered is whether free health care really ensures equal access to health care services, as was originally intended. Who pays and who gains?

Dr. Haviland foresees some slowing in health care spending over the next ten years. Working in the opposite direction, however, is the aging process of the population, since elderly people need relatively more health care.

Rae McIntyre Chittick, recognized throughout the world as one of Canada's most distinguished nurses, was honored at CNA's annual meeting for her tremendous influence on the nursing profession. In her introductory remarks, **Thurley Duck,** president of the RNABC, highlighted Dr. Chittick's career, a career that includes: a formal education at Johns Hopkins School of Nursing, Columbia University and Stanford; receipt of a Master's degree in Public Health; appointment as Director of the School for Graduate Nurses at McGill University; full professorship at McGill's School of Nursing; president



of CNA, AARN, and vice-president of the ONQ; and membership in the Order of Canada in 1975.

As a pioneer in establishing courses and degrees in nursing education in Canada, Dr. Chittick insisted that they incorporate a strong base in the humanities as well as the biological and social sciences. Internationally, her influence has been felt in Ghana, Jamaica and New Zealand where she helped to establish university schools of nursing with the World Health Organization.

After CNA president Joan Gilchrist presented her with a jewelled pin of CNA's emblem, the leaf and the lamp, Dr. Chittick related many anecdotes to the audience of her past nursing experiences. Her gentle humor and great dedication to nursing and to humanity will be remembered.



Photos by Studio Impact

Head table guests at the annual meeting luncheon were (left to right): Helen K. Mussallem, (CNA executive director); William Haviland, Economic Council of Canada; Shirley Stinson, CNA first vice-president; Bruce Rawson, Deputy Minister, Health and Welfare Canada; Joan Gilchrist, CNA president; Justice Antonio Lamer, Law Reform Commission; Helen Taylor, CNA president-elect; Rae Chittick, CNA honorary member; Sheila O'Neill, CNA second vice-president.

Report to membership

Delegates and participants at the CNA annual meeting heard association executive director, Helen K. Mussallem, review the program of CNA activities over the past eight months since the 1976 biennial meeting in Halifax.

The report, close to 50 pages in length, contains details of action taken to implement the 28 resolutions approved by membership in Halifax, information on the status of ongoing association projects, liaison with other national agencies, international, provincial and local official bodies.

Through these CNA activities, the "voice of organized nursing in Canada" is now heard at conferences, committee meetings, consultations and workshops of more than 100 agencies active in the health field. As a result, nursing input has been achieved in projects that range from the development of a Canadian Girl Guide health evaluation form to be completed by nurses, implementation of survey findings on cervical cancer screening programs, venereal disease and abortion, to development of occupational health and health promotion programs throughout Canada. In addition, members and staff of the association have actively promoted progress within the profession in the areas of nursing education, research, practice, administration and social and economic welfare of its members.

Resolutions

Membership concerns, as expressed in the resolutions presented to the last annual meeting, (*Canadian Nurse,* August, 1976) have been acted upon in a variety of ways, including communication with appropriate government authorities, health and consumer associations, representation at meetings, staff and executive committee action.

Current CNA programs

- *Standards for nursing education:* final report of CNA ad hoc committee scheduled for Fall, 1977.
- *National standards for nursing practice:* CNA assistance being provided to Health and Welfare program aimed at development of national standards.
- *Director of Labor Relations Consultation Service:* Selections committee to announce name of successful candidate shortly.
- *National survey on expanded role nurses:* data on 3,317 questionnaires returned by community-based nurses now being analyzed; report scheduled for publication in June 1977.
- *Research methodology workshop:* sponsored by CNA in cooperation with University of Ottawa school of nursing, will take place November 9-11, 1977 in Ottawa.
- *Nursing abroad program:* Since June, 1976, a total of 185 requests have been processed from persons outside Canada wishing to enrol in educational programs in this country. More than 160 nurses from other countries who requested information on employment opportunities through CNA have been advised of the current scarcity of jobs. International visits and study tours were arranged for 23 nurses from abroad.
- *CNA Testing Service:* final approval was given in November to the first blueprint for a comprehensive examination to be developed simultaneously in French and English. It is expected to be ready for use by 1979.

The number of in-country, first-time candidates writing present five-part examinations has remained fairly constant over the past four years (7,804 in 1975-76 and 7,650 in 1972-73). In that time, the number of diploma candidates decreased by two percent (6,966 in 1975-76) while the number of baccalaureate candidates increased by 58 per cent (838 in 1975-76).

International liaison

- *International Council of Nurses:* Canadian nurses will be well represented at the upcoming ICN Congress in Tokyo. More than 400 CNA members have registered. CNA president Joan Gilchrist, a voting member of ICN's Council of National Representatives, will represent the association. CNA has nominated two Canadian nurses, Verna Huffman-Splane and Nicole Du Mouchel for the positions of vice-president and member-at-large, respectively, and is supporting two other nominations.

At the request of the international association, CNA has also provided topics for two agenda items and names of Canadian nurses willing to participate in the special interest sessions.

- *IXth International Conference on Health Education:* CNA was a co-host and co-sponsor for this conference in Ottawa last September. More than 1000 delegates from 82 countries were in attendance.
- *King's Fund College International Seminar for Nurses:* Canadian participants in this July meeting in London, England, included CNA Board members Shirley Stinson, and Lorine Besel, past president Huguette Labelle, executive director Helen Mussallem, Ada McEwen (VON) and Dorothy Kergin (McMaster University).
- *Other international agencies:* communication was maintained with the Commonwealth Caribbean Regional Nursing Body, Commonwealth Nurses Federation, American Nurses Association, Royal College of Nursing, World Health Organization, Pan American Health Organization, International Hospital Federation and others.

Other national agencies

Special interest nursing groups: CNA continues to provide support and guidance through working relationships with numerous nursing associations including: Canadian Association of Neurological and Neurosurgical Nurses, Nurses Employed at National Level, Registered Nurses of Indian Ancestry, Victorian Order of Nurses, National Committee of Nurse Mid-wives, Psychiatric Nurses Association of Canada and Canadian Nurses Foundation.

Canadian Council on Hospital Accreditation: CNA representation on the CCHA Board of Directors has been increased to two persons following a decision of the CNA directors in October. The new nursing representative will be named shortly.

Other health-related groups: Liaison and collaboration at the national level includes information sharing with groups such as: Canadian Hospital Association, Canadian Public Health Association, Canadian Medical Association, Health League of Canada and Canadian Council on Smoking and Health.

Extension Course in Nursing Unit Administration: a joint CNA and Canadian Hospital Association project, the NUA extension program consists of a combination of workshops and correspondence programs available in both French and English. Since 1960 when the program was initiated, a total of more than 7000 nurses have taken the course, including nurses in Zaïre, Botswana, Haiti and Lebanon.

Announcement that the Canadian Hospital Association, which now houses the NUA staff, will move its headquarters to Ottawa this September has resulted in establishment of a sub-committee to study the question of relocating NUA offices. →

News

Since June 1976 the five CNA representatives to the NUA Joint Committee, at the request of CNA directors, have carried out an evaluation of the NUA program. Their conclusion: enrolment has increased significantly in almost all provinces and the number of graduates per year would indicate that the objectives of the course are being met.

Government departments

Health and Welfare Canada: Meetings and consultation take place as needed between CNA staff and officials of Health and Welfare Canada, including Minister Marc Lalonde, the Minister of State for Fitness and Amateur Sport, Iona Campagnolo, the new Deputy Minister, Bruce Rawson, acting Principal Nursing Officer, Rose Imai and various department heads.

CNA input into proposed legislative changes, task forces and research programs has increased substantially in recent months. Areas of consultation include: the new Social Services Act (replacing current Canada Assistance Plan), proposed legislation for extended health care services, Canada Health Survey, proposed physician manpower data bank, Task Force on Cervical Cancer Screening Programs and Working Group on Venereal Disease Control.

Canadian International Development Agency (CIDA). During 1976, CNA was instrumental in securing and administering CIDA/NGO funds totalling close to $65,000 for the development of nursing programs in many countries around the world. Last year CNA was granted funds for eleven projects in nine countries in the Third World.

CNA has just learned that a submission for funds to conduct a feasibility study on producing an international French-language periodical for developing francophone countries has received CIDA/NGO approval. The total financial request for $22,500.00 has been awarded.

At a meeting of all professional voluntary agencies called by CIDA/NGO (2-3 March 1977), CNA's program was commended as an example of what a national voluntary agency could accomplish.

National office personnel

Statistical program: The "Resource File" of Canadian nurses with a baccalaureate or higher degree is being expanded to identify areas of expertise, and determine availability for special international or domestic assignments. A new questionnaire entitled, "Professional Profile on Canadian Nurses," has been mailed to all Canadian nurses holding a master's or doctoral degree. Basic information will be put on the "in-house" computer for ready reference and the completed questionnaires will be retained in the library biographical files. Information on baccalaureate nurses is being maintained for 1977 and will soon be computerized.

Canadian Nursing Statistics: which replaces CNA's *Countdown,* was produced for the first time in 1976 by Statistics Canada. Although publication is now the responsibility of this government department, CNA still coordinates provincial inventory data collection, collects and tabulates the necessary data and information.

Library: both services and resources have increased steadily. CNA members have access, through the library to: Repository Collection of Nursing Studies, foreign nursing journals, Canadian and foreign nursing legislation, collective agreements, continuing education programs, biographical files, foreign service records, photo collection and the archives, in addition to 13,000 books and documents.

Journals: response to the new format which emphasizes visual unity of both *L'infirmière canadienne* and *The Canadian Nurse* has been enthusiastic and, almost without exception, favorable. Support from CNA members, in the form of manuscripts submitted for editorial consideration, has increased measurably within the past year. This has enabled the editors to make a significant improvement in the quantity and quality of articles presented to readers each month.

Information Services: Early in 1977, a director of public relations services was appointed. Nicole Fontaine has worked as a journalist, broadcaster and consultant for agencies that include Health and Welfare Canada, Secretary of State and Treasury Board. Current information services projects include publication of a bilingual pamphlet on basic nursing education for the use of high school students and guidance counsellors, an audiovisual slide presentation on CNA and a newsletter for member associations.





Pictured during the 1977 annual meeting are (left to right) RNAO acting executive director, **Doris Gibney** *with* **Marjorie Hayes,** *director of the joint St. John Ambulance/Canadian Red Cross project and, at the mike,* **Thurley Duck,** *president of the B.C. nurses' association.*

Voting delegates at CNA's annual meeting approved four resolutions with implications that could affect all practicing nurses in this country. The resolutions directed the association to:

1. strongly urge the Government of Canada to include the costs of (professional) publications in their yearly **income tax deductions.**
2. re-emphasize the purpose of the **(Canadian Nurses Association Testing Service)** scores to be solely the determination of eligibility for licensure in a participating jurisdiction, and discourage the use of registration examination scores by educational institutions as a criterion for admission into educational programs.
3. pursue the initiatives taken over the last year by giving its full support to the implementation on a national scale of the following RNABC **recommendations concerning rape:**

- Inservice orientation programs for staff in hospital emergency departments including information on treatment of victims of sexual offences.
- An association position calling on all hospitals to treat all cases alike, whether or not charges are to be laid.
- Making information on treatment of rape part of schools of nursing curricula and make further representations to the Minister of Justice to proceed with the adoption of all changes recommended by the Law Reform Commission in relation to rape trials, as expressed in its report on evidence.

4. be instrumental in the development of a **Canadian Code of Ethics for registered nurses.**

Highlights from CNA Directors' meeting

Organized nursing will be active on many fronts in months to come. Directors of the Canadian Nurses Association, meeting in Ottawa at CNA House on March 30 and April 1, moved to fill some of the gaps they recognized in the area of current nursing practice, research, education and administration. At the same time, they took a look outside the profession at the ways that nurses could be contributing to the improvement of the health status of persons around them and the potential for nursing involvement in the work of agencies with compatible goals. Highlights of their discussion and decisions follow:

Nursing practice

An expert in the field will be selected from names submitted by member associations to develop a preliminary definition of nursing practice.

Registration / licensure

An expert will be hired to develop a discussion paper on principles, alternatives, implications and strategies in this area. Both this project and the one on nursing practice will be carried out on a contract basis.

Canadian Association of Neurological and Neurosurgical Nurses

Directors approved an application by CANNN for affiliate membership with CNA. CANNN thus becomes the first affiliate member of CNA in the association's history.

Doctoral preparation for nurses

Outside funding will be sought for a proposed conference to investigate problems and priorities in the area of doctoral preparation for nurses in this country. At present, fewer than 50 of 115,000 CNA members hold doctoral degrees. The vast majority of these were obtained in the U.S. The proposed conference is planned for December, 1977.

Workload measurement system for nursing in the hospital field

Directors voted to accept the invitation of the Chairman of the Steering Committee on Workload Measurement Systems to participate in its work of promoting the development of adequate workload measurement systems as they relate to hospital nursing. The steering committee was set up in November 1975 by the federal-provincial Advisory Committee on Health Insurance. Last year it provided supervision, advice and assistance in relation to development of workload systems for laboratory medicine, radiology, respiratory technology, dietetics, and hospital pharmacy.

Directors pointed out that workload measurement in hospital nursing has a direct bearing on current provincial concerns in the area of fiscal constraints and quality assurance programs.

Protection of life

Directors indicated interest in the invitation extended by officials of the Law Reform Commission of Canada to participate in the commission's current work in the area of protection of human life. The project, dealing with euthanasia, a definition of death, human experimentation and behavior modification and control, was described to CNA members by the chairman of the commission, Justice Antonio Lamer, at a luncheon during the annual meeting.

Meetings between CNA representatives and commission officials will take place to explore possible nursing input.

Special interest groups in nursing

CNA directors approved preliminary guidelines that will allow the national association to take the initiative in providing both moral and financial support to "emerging" groups representing special interests within the nursing profession. Financial support will be limited to $500 in the initial year and goals of these groups must be compatible with those of the national association.

Principal Nursing Officer

Acting PNO, Rose Imai, reported on current programs and concerns within the federal department of Health and Welfare. These included:

- new cost sharing arrangements between the provinces and federal government in the area of hospital and medical care insurance and post-secondary education.
- federal/provincial nursing consultants meeting scheduled for September 26-28 in Ottawa.
- government action to alleviate the current depressed market situation for nurses and provide better long-term nursing manpower planning.
- recognition of the need for a national policy on immunization and work begun on this project.
- establishment with the Department of Labor of a National Center for Occupational Safety and Health.

Water resource planning and management

Acting on a resolution passed by CNA members at the 1976 annual meeting when "quality of life" was the theme, directors supported development of a "clean water campaign" among members of the nursing profession in Canada. A variety of ways will be sought to stimulate nursing interest in water supplies and water problems in this country.

1977 Budget proposal

The Treasurer's Report, presented to the annual meeting by executive director Helen K. Mussallem, indicated that expenditures for consolidated operations for the 1976 fiscal year were $2,056,140 which was $9,740 under consolidated revenues of $2,065,880.

The 1977 budget proposal approved by the directors at their meeting on March 30 projects expenditures of $2,626,478 and revenues of $2,281,158 producing a deficit of $345,320.

This deficit was foreseen by the voting delegates at the 1976 annual meeting when the fee unit of $18, required to support approved programs, was adopted for phasing in over two years—$12 in 1977 and $18 in 1978. The deficit generated by the $12 unit fee in 1977 will be recovered with the introduction of the $18 unit fee in 1978.

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CONNAUGHT

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News

Family planning moves into high gear, nurses active in federal program

Two nurses will be key members of the team directing the more active role that federal Health and Welfare Minister Marc Lalonde envisions for the Family Planning Division of his Department.

Suzanne Brazeau, was appointed Director of the Division in July, 1975. A native of Kirkland Lake, Ontario, Brazeau obtained her R.N. at the Ottawa General Hospital. She is a graduate of the University of Ottawa (B.Sc.N.Ed., B.A., L.Th., and M. Th.) and the University of Chicago (M.A. and Ph.D dissertation not finished).

She was formerly Health Education Consultant and Nursing Coordinator with the Canadian Tuberculosis and Respiratory Disease Association.

Pauline Chartrand was named nurse consultant for the Family Planning Division in mid-March of this year. A graduate of the University of Ottawa (B.Sc.N., B.A.), Chartrand is now enrolled in the Master of Health Administration Program at U. of O. Her experience includes work as director of Montfort Hospital School of Nursing in Ottawa and as a Public Health Nurse with the Ottawa-Carleton Regional Health Unit where she was one of two nurses seconded to a three-year demonstration project carried out by the Health Unit, "An Investigation into the Health Care Needs of the Elderly in Senior Citizen Apartments."

The four-year-old family planning division has been in existence since January 1972, but until now has maintained a low profile, restricting its activities to responding to requests for information,consultations and grants. The new policy announced by the Minister involves a shift to active promotion and publicity of family planning, in response to the findings of the Committee on the Operation of the Abortion Law (the Badgley Report). In a statement released shortly after publication of the Report, the Minister noted that: "Although the federal government does not consider abortion to be an acceptable method of family planning, it is accepted that abortion counselling, meaning the objective presentation of several alternatives, lies within the laws of Canada as defined by Parliament."

"Abortion counselling services should be provided in family planning facilities as long as all the possible options are fairly and clearly presented, and as long as the terms of the Criminal Code are fully respected."

The Minister pointed out that it was the government's intention to highlight the federal perspective and also to stress prevention and the desire to improve lifestyles to a significant extent."

"In keeping with the fundamental objective that every shild should be a wanted child, the Family Planning Program will devote attention both to conception and contraception, so that Canadian couples may freely choose to have a child when they want one."

In addition to a more active role in promoting family planning information, the division will focus its advisory and consultative services on assisting the provinces and voluntary agencies to develop family planning services.

Other initiatives include:

- Placing the issue of age of consent relative to counselling and treatment services on the agenda of the next conference of ministers of health and welfare.
- Assisting provincial officials with the training of personnel.
- Encouraging provincial ministers to create "approved" hospital services and to provide the necessary staff and supplies in order to offer the needed family planning services.
- Discussing with the provinces the feasibility of establishing women's clinics affiliated with general hospitals.
- Making physicians more aware of the terms of the legislation respecting abortion.

Nursing groups are encouraged to apply for training grants, teaching fellowships, demonstration service and education grants and research grants.

Information is also available to groups or individuals. Of particular interest to nurses are the following:

- Family planning manual for nurses;
- Communications in family planning;
- Contraceptive technology (in English only);
- A manual on establishing and operating Community Family Planning services;
- Sex Education — a teacher's guide.

The division also has on hand a broad range of pamphlets for the general public.

Did you know ...

A unique brochure **"Passion Food Isn't Enough"** has been released by the division of Community Health, University of Toronto and attempts to answer questions about nutrition and family planning. Copies available from: *The Family Planning Division of National Health and Welfare, Room 662, Brooke Claxton Building, Ottawa, Ontario, KIA IB5.*

ICN announces 1977 3M Winners

The International Council of Nurses has announced the names of the two recipients of 3M Fellowships for 1977. They are Hertta Kalkas of Helsinki, Finland, and Jean Grayson of Trinidad and Tobago. The fellowships are valued at $6000 (U.S.) each and are awarded annually under a program sponsored by the Minnesota Mining and Manufacturing Company (3M) and administered by the ICN. A total of 44 national nurses' associations submitted names of candidates for the 1977 awards. CNA's nominee this year was Denyse Latourelle of the University of Montreal in Montreal. Each of the national finalists receives a prize of $200.

Last year's winners were from Thailand and Mauritius. Canada's last fellowship winner was Alice Baumgart of Toronto and Vancouver who received the award in 1973.

Health exchange program receives official approval: *Canadian-Cuban opportunities for information sharing in the health care field will continue to expand over the next two years as the result of a joint agreement signed recently in Ottawa. Below, Canada's Minister of Health and Welfare, the Hon. Marc Lalonde, shakes hands with the Minister of Public Health for the Republic of Cuba following the official signing of the agreement in Ottawa, March 29.*



Health Minister Jose A. Gutierrez Muniz, in an interview following the ceremony, paid tribute to the "very high level of nursing education and practice in Canada" and said that Cubans "very much admire the expertise and experience of nurses in this country." He pointed out that Cuba had only recently acquired its first university program in nursing and that Cuban nurses involved in setting up the program had relied heavily on experiences acquired in Canada during a study tour arranged through the exchange program.

The new agreement provides for continuation of a 1975 exchange program between Canada and Cuba. The latest agreement, according to Health Minister Lalonde, is more specific to nursing and offers nurses in both countries greater opportunities for collaboration and co-operation.

Correction

Re CNJ's March news item page 16: The newly elected Western chairperson of CUNSA is **Bonnie Smith,** University of Saskatchewan; **Kathy Toner,** Atlantic Regional Research Coordinator, is from the University of New Brunswick.

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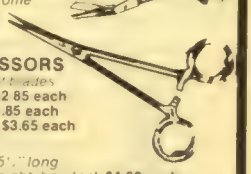
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News



Montreal nurse heads accreditation body

Helen Taylor, president-elect of the Canadian Nurses Association and director of nursing at the Montreal General Hospital has been appointed chairman of the board of the Canadian Council on Hospital Accreditation and chairman of that association's Executive and Finance Committee. The appointment marks the first time in history that a nurse has filled the position of CCHA board chairman.

The Canadian Nurses Association has held a seat on the CCHA board since March 23, 1973. Isobel MacLeod, then director of nursing, Montreal General Hospital, was the first CNA representative on the board. She was succeeded by Taylor in August 1974. CNA acquired a second seat on the board in February 1977 and has named **Fernande Harrison,** Administrative Professional Officer, Dept. of Medicine, University of Alberta to fill that position.

The Canadian Council on Hospital Accreditation establishes standards for hospital operation and promotes high quality medical and hospital care for patients. On a voluntary basis, hospitals invite CCHA surveyors to examine their hospital services. At present, nearly 60 percent of the 904 public general hospitals in Canada are accredited by CCHA. This accounts for 83 percent of all hospital beds.

Rcn Fellow named acting ICN head

The former chief education officer of the General Nursing Council for England and Wales, Barbara Fawkes, OBE, BSc, SRN, SCM, has been named acting executive director of the International Council of Nurses until the ICN Board of Directors names a successor to Adele Herwitz whose resignation became effective March 31.

The acting executive director has been a member of the ICN Board of Directors since 1969. She has resigned from this position to take up the staff appointment.

An active member of the Royal College of Nursing of the United Kingdom throughout her career, Fawkes was awarded a life vice-presidency of the College and was among the first group of ten nurses to be made a Fellow of the College. Fawkes is an Honorary Fellow of the New South Wales College of Nursing, Australia, the country where she now resides.

University of Alberta Graduate Scholarship

A graduate scholarship of $1,000 is awarded annually by the University of Alberta Hospital Board in recognition of the 50th anniversary of the schools of nursing of the University of Alberta and University of Alberta Hospital. The scholarship is awarded to a graduate of the University of Alberta Hospital School of Nursing who has been accepted in a University program for advanced nursing education at the Baccalaureate, Master's or Doctoral level.

Applications will be assessed according to the applicant's potential for leadership in nursing, contribution to nursing and to the community, references, and fulfillment of educational criteria.

Applications for this year's scholarship are to be submitted by June 30, 1977 to: Vice-President — Nursing, University of Alberta Hospital, 112 St. and 83 Avenue, Edmonton, Alberta, T6G 2B7.

St. John/Red Cross multi-media project

A Canadian nurse with a background in curriculum development, classroom and clinical teaching as well as administration of research contributions and grants in the Federal Government, has been named project director for the joint St. John Ambulance/Canadian Red Cross multi-media home nursing program. Marjorie Hayes (Reg. N., Cornwall General Hospital; B.Sc.N., University of Windsor; M.Sc.N., University of Western Ontario, London;) heads up the three-year research project directed towards the teaching of basic home nursing skills to a large segment of the Canadian population.

Funding for the project has been provided by National Health Research and Development Program of Health and Welfare Canada.

"What we're trying to do," according to Hayes, "is to find the best way of helping the individual provide care with confidence, not just to members of his immediate family but also to the "extended family" in the community.

The multi-media program involves the production of a total of 26, 16 mm films, half in French, half in English for home television viewing along with programmed learning texts and additional instructional aids. Each film will be thirteen and one-half minutes in length and filmed in color. The segments are to be centered around personal situations, and the case study approach will be used to teach principles and skills of home nursing.

The project which was originally conceived nine years ago by another Canadian nurse, Margaret Hunter, chief nursing officer, St. John Ambulance, is to last three years. During the first 18 months, the multi-media program will be produced and the evaluation design and procedures will be set. In the next 12 months, volunteers will enrol in the program, and the evaluative research will be conducted in nine communities across the country. Province-wide distribution of the new program will begin in the Fall of 1979 from the two agencies.

Hayes was formerly Project Administrator for Research Program Directorate, Health and Welfare Canada. In this capacity she planned organized, directed, examined and analyzed applications for financial assistance under the National Health Research and Development Programs to determine their administrative and operational feasibility. As director of the joint St John Ambulance/ Canadian Red Cross project, she looks forward to involving nurses in the community i various components of the program a it develops. "It is only through the co-operation of nurses across Canad that this project can succeed," she says.

CNA appoints director of Labor Relations Service

At press time, CNJ learned of the appointment of Glenna S. Rowsell a CNA's first director of Labor Relation Services. Most recently employed with the Provincial Bargaining Councils of New Brunswick and a former member of the CNA board o directors, Rowsell will establish and direct a labor relations service whic includes collection and analysis of data, preparation and distribution o information and development of relevant educational programs.

PEI nurses promote changes in property laws

The Association of Nurses of Princ Edward Island has submitted a brief t Minister of Justice Alex Campbell, urging that changes be made in matrimonial property law to reflect th premise that the institution of marriag is, in part, an economic partnership equals, and that the family structure in part, an economic unit.

The brief points out that the existing matrimonial property law regime of separate property results inequities between men and wome and that it fails to recognize the unpa contribution of the spouse in the hom and the contribution of wives in unincorporated family farms and businesses.

FRANKLY SPEAKING

GOVERNMENT FOR WHOM?

Linda Gosselin



For the past year and one half in Ontario, public health nurses have faced a problem that is now beginning to rear its ugly head in other provinces, British Columbia in particular.

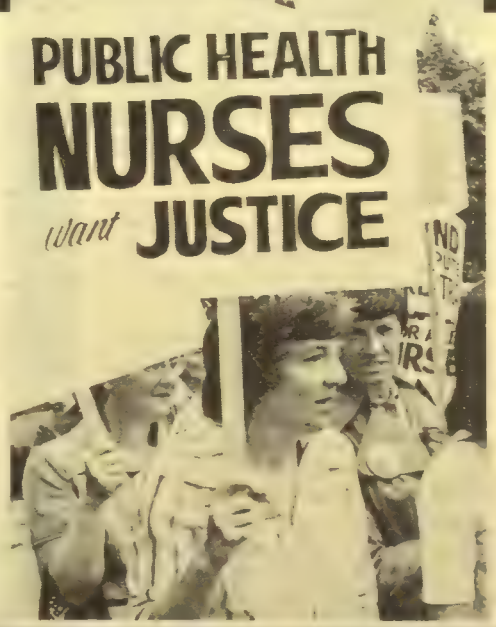
Simplistically stated, the problem of the Ontario public health nurse is: "Are her services essential enough to rate arbitration of contract disputes?" At present, unless her collective agreement has an arbitration clause, or her employer agrees to take unagreed issues to arbitration, a public health nurse's only recourse if she does not accept a contract offer is to go on strike or be locked out by the employer. The majority of the local Boards of Health in Ontario have agreed among themselves not to settle for arbitration. The provincial government has been noted for its lack of action to solve the impasse. It seems they do not wish to interfere with the autonomy of the local Boards of Health. Petitions, letters, strike action by the nurses, and prolonged lock-outs of nurses by their Boards have been unable to move them.

Now in British Columbia, we see another group of nurses faced with a problem like the one in Ontario. The nurses in British Columbia have been 18 months trying to settle a contract with the B.C. Government Employee Relations Bureau (G.E.R.B.). They too, wish to take unsettled issues to binding arbitration. G.E.R.B.'s response to arbitration is: "No; accept the offer or be prepared to take a strike."

I find I cannot accept such unreasonable positions from governments elected to provide services to the public within their provinces. In Ontario, the government is risking a cessation of public health nursing services; in B.C., the nurses being pushed towards strike action provide services in psychiatric and rehabilitation hospitals and in community health agencies. Whose interests are the governments trying to protect? The nurses' — obviously not; the public's? — obviously not their interests either.

The nurses in both disputes have gone on record backing arbitration as the best way to settle contract disputes because of the patients who would and do get caught in strike action. The difficulty is getting the respective provincial governments to act in a responsible manner to provide the necessary legislation to allow peaceful settlement.

Recently, the Ontario Nurses' Association presented a brief to the Ontario Government. In it, O.N.A. highlights the "disastrous state" that collective bargaining for nurses is in, in Ontario. O.N.A. maintains that: "This state has been created through the failure of the Ontario Government to exercise its supervisory role over collective bargaining. The needs of the nursing profession have ...been steadfastly ignored and registered nurses remain second class citizens in this province." Is B.C. heading in the same direction?



Photos by Suzanne Emond, RN

Frankly Speaking is intended as a forum for nurses who want to speak out on issues that may influence the future of nursing practice, research, administration or education. Guest columnist this month is Linda Gosselin, CNA member-at-large for social and economic welfare. If you have an opinion or concern that you would like to share with your fellow nurses, why not write to us. This is your chance to get involved, to participate in shaping the destiny of your profession.

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for tired legs and aching back

Stella Weller

I often recall my early days as a student nurse in England. The first three months were spent in Preliminary Training School where we sat in a classroom for several hours a day. We listened to lectures, made notes and wrote tests. Then we went on to the wards, and what a difference that was! I shall never forget how hot, tired and aching my feet felt at the end of an eight-hour day. Nor will I soon forget how quickly I kicked off those black, lace-up Oxfords when I got back to my room at the nurses' hostel, and how I flopped into bed, missing supper, "The Boy Friend," and all the other shows and concerts for which, often, there were free tickets.

If only I had known about Yoga in those days! But it was many years later, in Trinidad, West Indies, that I discovered it when I found a book on the subject in the house of the friend with whom I lived. I learned that Yoga was a practical science that originated in India thousands of years ago and that one branch of it, Hatha Yoga (the Yoga of health), was rapidly gaining popularity in the Western world as a means of restoring and maintaining mental and physical well-being. I read that neither age, nationality nor creed were barriers to its practice which included physical exercises and breathing techniques. What fascinated me most was the way in which the exercises were done — in a very aware manner, slowly and smoothly, with breathing and movement synchronized. There was a "holding" period in which the pose was maintained, in comfort, for several seconds, while the breath was allowed to flow freely. Finally, there was a rest period to allow an absorption of energy and elimination of fatigue poisons accumulated through muscular activity.

I decided that this was for me, and by the time I came to Canada I had begun to practice Yoga asanas (postures or exercises) with some regularity. My first job was on a busy orthopedic ward that was invariably short-staffed. After many









hours of bending and lifting and walking back and forth, plus a ten-minute walk to and from the bus stop, I was ready to crawl into bed at my tiny apartment. Not only were my feet and legs throbbing and weary, but my back protested in the worst way. I suppose that having a marked scoliosis did not help matters. However, instead of retreating to the tempting comfort of my bed, I summoned up the initial courage I knew I needed to do some Yoga. Kicking off my shoes and removing my stockings, I slipped out of restricting garments and began. My first thought was of the **Half Shoulderstand,** an old favorite. Its inverted position helps the return flow of blood to the heart and provides rest for the valves of the blood vessels in the legs; it helps counteract the many undesirable effects of the constant downward pull of gravity. Moreover, it encourages a better blood supply to the upper body; the brain cells benefit, as do the face, eyes, and hair.

Here's how to do it:

1 Lie supine on a floor protected by blankets or carpet. Arms are close to you and palms turned down. Breathe easily.
2. Exhale and raise straight legs until they are perpendicular to the floor. Inhale.
3. Exhale and raise hips off the floor by using the elbows and hands as levers, while simultaneously swinging the feet backward (See figure 1). *Continue breathing normally.*
4. Keeping the upper arms on the floor, support the hips with the hands, thumbs in front (See figure 2).
5. Hold the completed position for as long as you are comfortable, letting your breath flow smoothly.
6. To come out of position, replace the forearms and and hands on the floor. slowly lower the torso until the hips are down; lower the legs on an exhalation. Rest until respirations are normal.

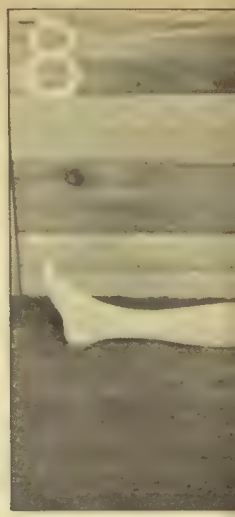
The **Dog Stretch** is another favorite of mine for relieving tension in feet and legs, and for bringing an overall feeling of refreshment. The head-down position is beautifying as it brings a better blood supply to the upper body.

1. Get on "all fours," thighs at a right angle to the torso, toes tucked under, and arms sloping. Breathe normally. (See figure 3).
2. Inhale. Exhale, press on palms and toes, lift knees and straighten legs; press heels toward the floor and push the hips up. The head hangs down and arms are straight (See figure 4).
3. Hold the position for several seconds, breathing rhythmically.
4. To come out of position, inhale and rock forward on the palms; lower knees and slowly resume your starting position. Sit on the heels or in any other comfortable position for several seconds, and rest until breathing normally.

On days when even the Dog Stretch seems to require too much effort, simply lie on a bed or padded floor, and rest your feet against a wall or on a piece of furniture. Close your eyes and practice conscious relaxation. Mentally suggest to each part of you, in turn, to release tightness, to let go, to relax — toes and feet, ankles and calves, knees and thighs, working up to and including your scalp. Finally, focus on your breathing, imagining an intake of refreshment and energy with each inhalation, and an outflow of tiredness and everything negative with each exhalation. I have practiced this technique many times in five-minute breaks during a hectic day. It has been a boon at such times, helping to restore my mental balance. I have even done it sitting in a chair, with my spine supported, and my feet on a prop.

One day at the local library, I found a book that explained why primitive people seldom suffer from tired backs or backache and why degenerative disc disease is virtually unknown among them.[1] Apparently, in cultures where people squat habitually rather than stand for long periods or sit on chairs, the lumbar arch of the spine is reduced, and strain on the paravertebral muscles and spinal discs is lessened. Perhaps that is





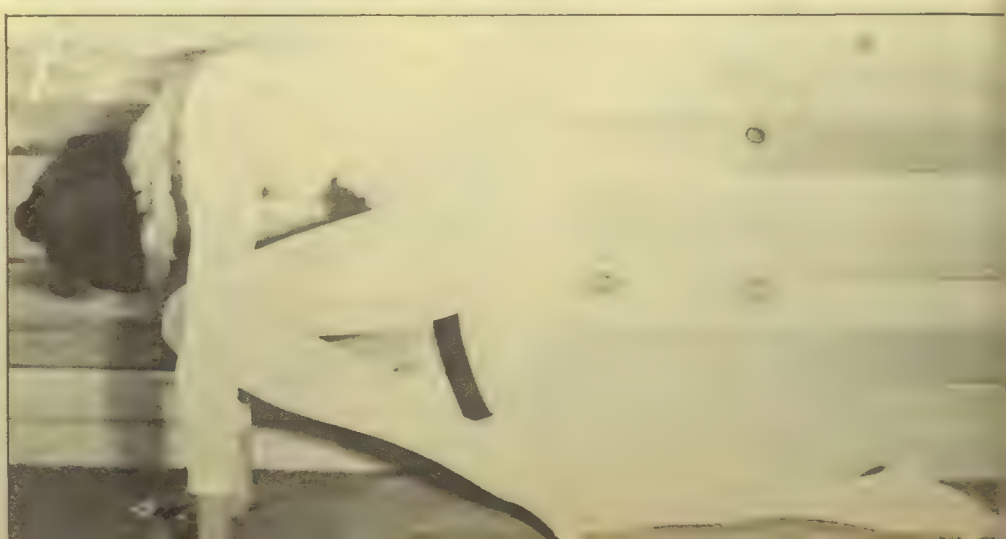
why the exercises that follow are so effective in relieving back fatigue and strengthening the muscles supporting the spine.

The Reverse Arch (combined with pelvic titling).
1. Lie supine with arms near you and palms turned down. Bend the legs and put the soles of the feet flat on the floor, a comfortable distance from the bottom.
2. Inhale. Exhale and press the small of your back into the floor to reduce the lumbar arch and tilt the pelvis upward.
3. Inhale and slowly raise hips then torso in a smooth, controlled manner, until the body from knees to chest is level (See figure 5).
4. Hold the position, breathing evenly.
5. In reverse motion, lower the torso by uncurling the spine into the floor. Stretch out the legs and rest.

The Cat Stretch (modified).
1. Get on hands and knees, like a table on four legs. Breathe regularly.
2. Exhaling, lower the head, press on palms to arch upper back, and tuck the bottom down (See figure 6).
3. Hold for several seconds, letting the breath flow freely.
4. Inhale and relax in your starting position. Repeat several times.
5. Exhaling, lower head and bring a knee toward the forehead (See figure 7).
6. Hold the position as long as comfortable, breathing evenly.
7. Inhale and resume your starting position. Repeat with the other leg.
8. Sit and rest until respirations become normal.

The Knee Press
1. Lie supine with arms relaxed beside you. Breathe regularly.
2. Exhale and bring a bent knee toward the chest; clasp the lower leg and bring the forehead toward the knee (See figure 8). *Keep your shoulders relaxed and hold the position for several seconds, breathing as evenly as possible.*
3. Inhale and lower head, arms and leg.







4. Repeat a few times with the same leg; rest and repeat the same number of times with the other leg. Relax.

The Dancer's Pose

The Dancer's Pose, in addition to being beneficial for the back, is excellent for improving blood circulation in the legs, for toning and strengthening them and the feet, and for helping prevent varicosities.

1. Stand naturally erect.
2. Inhale and rise on to the toes, raising the arms overhead and bringing the hands together (See figure 9).
3. Exhaling, slowly lower the bottom toward the heels (See figure 10).
4. Unless you have varicose veins, hold the position for as long as comfortable, breathing normally.
5. If you have varicosities or do not wish to hold, omit step 4 but repeat steps 2 and 3 several times.
6. Sit and rest.

Finally, for all of us who, at some time or other, will sit hunched at a desk for several hours, or spend much time bending forward, here is a technique that is marvellous for counteracting the effects of faulty posture and relieving back strain; for releasing tension from the shoulder area and for bringing a better oxygen supply to every cell. It is called the **Chest Expander**, and has been modified.

1. Stand naturally erect (you may sit also on a stool, bench or box).
2. Inhaling, swing your arms behind you and interlace the fingers. Push the arms upward, but resist the tendency to bend forward; maintain an erect posture (See figure 11).
3. Exhale and bend forward from the hip joints, keeping the chin and arms up (See figure 12).
4. Hold the position as long as comfortable, breathing rhythmically.
5. When the impulse to come up appears, do so, very slowly, keeping arms pushed upward and torso straight.
6. Relax arms, shrug a few times or rotate the shoulders, shake imaginary drops of water from the hands, and rest.









It is not necessary to wait until you get home after a tiring day to practice the foregoing exercises. Do them, as I have done and still do, during coffee and meal breaks (before you eat), in the locker room or elsewhere, and on any convenient occasions you find or create during the course of your busy day. Take your shoes off, loosen your collar and belt, and have a yoga break. It will help forestall a build-up of tension and fatigue, and do much to conserve needed energy for physical and mental creativity.

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Yoga expert **Stella Weller** *grew up in Guyana, South America. Her nursing education took place at Charing Cross Hospital in London, England, where, she says, most of her experience was gained through work on maternity wards, prenatal and postnatal clinics. Her Canadian nursing experience includes a stint at Lion's Gate Hospital in North Vancouver, and at Notre Dame Hospital in Zenon Park, Saskatchewan. She lives now in Surrey, B.C. with her two sons and husband, Walter who took the photographs that accompany this article.*

The Rewards of Research

The researcher holds the baby, who is all dressed, alert, not tired and, we believe, happy and comfortable after his cuddle bath. Note the eye contact he makes with the author.



CUDDLE Bathing can be Fun

J. Penny Iles/Marcia McCrary

A bath is often a welcome, relaxing high-point of the adult's day. Not so for the infant. Suspecting the method as the cause for upset, these authors compared a new technique with the traditional one — and saw some satisfying results.

Two harried clinical nursing instructors on a busy university medical center maternity service are among those least likely to have heard the frequent challenge of peer-professionals: *Put a little excitement in your life — try research!* What we did hear were squalling babies in the nursery, particularly at bath time.

The anxious faces of their mothers told us that they hadn't missed the apparent distress of their infants, either. "Babies always cry at bath time," we've heard seasoned mothers reassure the new. "It's good for babies to cry; it clears their lungs," they counsel. But most young mothers aren't convinced, and neither were we. Watching babies nakedly await the brisk water and rub of diligent nursery staff, one young mother suggested thoughtfully, "Maybe they're simply cold."

We felt she could be right. But if we were to challenge, perhaps change, routine bath procedures we would have to validate the need, possibly offering a feasible substitute. The need for change seemed obvious. For adults a bath can be a relaxing, soothing experience. Yet the babies' cries seemed anything but relaxed. If we operated from the assumption that these babies were responding with distress (squalling, motor excitement) to a stimulus (the routine bath procedure) and hypothesized that this event stressed the infants thermally as well as emotionally, we had the skeleton of a physiologically-related clinical study. Acknowledging the well-sung need for such nursing research, we eagerly made the plunge.

What if we monitored babies before and after routine bathing to detect changes in body temperature which might be correlated with the procedure? During baths we would measure physical activity and intensity of crying. The data so obtained might validate a

need to alter routine bathing practices so as to reduce babies' thermal and behavioral stress. Moreover, if we monitored babies who experienced several different daily bathing techniques in a variable sequence, would one or more techniques be found substantially less stressing? The use of such techniques could thereby be justified clinically.

We struggled with the details of clarifying our goals, formulating a plan of attack on this "clinical problem." We shoveled through a variety of library resources, extracting previous research, sorting theories sifting out variables, scrutinizing techniques related to infant bathing. We unearthed information suggesting the abilities of newborns to adjust to changing environments, various methods used in assessing the thermal status of infants, controversies regarding the effect of thermal stresses upon the metabolism and oxygen consumption of the neonate, and correlations between the presence of brown fat and thermal regulation capabilities of infants.[1—9] (For more information on thermal regulation see Williams and Lancaster).

We discovered conflicting reports on the effects of a variety of infant-bath procedures; some argued against the necessity of such practices while others decried the lack of bathing procedures.[1,2,10,12] Several affirmed when and where to bathe infants: a few suggested when and where one should not complete the procedure.[2,5] Data supporting how to bathe infants ranged from those which favored the use of no soap to one instance in which even water was eliminated.[5,13,14]

Through this search of the literature we identified the parameters for the "normal newborn" in our study and the techniques by which we would record the anticipated thermal adjustment of study infants. We elected to study thermal and behavioral data from infants during three distinct procedures:

1 the bath routinely given by nursery personnel;

2 the bathing technique we teach our students during clinical experience in the newborn nursery; and

3 a wrapped-bath technique we adapted from the towel-bath procedure used for adults in the study setting.[15]

Carefully wording our proposal, we secured appropriate clearance for conducting the study on the maternity unit and prepared the tool upon which to record our data for ensuing computer analysis. We scrutinized our teaching schedules and, finding no ready time for research, we made the time by devoting 6 a.m. on weekdays, a time prior to







The Cuddle Bath — Step by Step...

The technique we developed in our research to discover a better bathing procedure for newborns is based on the idea that exposure of the baby's skin before, during, and after his bath is what makes the baby so unhappy. The new technique, which we have affectionately nicknamed the "cuddle bath," begins with the folding of an old, soft towel into quarters. Then starting with the folded edges, the towel is rolled up and inserted into a plastic sack, rolled edges first.

Warm water (99°F) is poured into the sack, which is squeezed a few times to thoroughly saturate the towel. Then the sack is turned upside down and squeezed to remove excess water from the towel. The towel should be damp, not wet.

arrival of clinical students, to collecting data in the nursery. We quickly learned that researchers have precious little time for their work and we were going to make the most of it!

On we waded, through four months of early-morning bathing. The information we gathered was eventually punched onto computer cards, which were sorted, resorted, and correlated. Excitement surged as we congratulated ourselves — slightly prematurely.

We had almost forgotten the warning that research can be frustrating as well as exciting. That truth struck boldly as the computer catabolized the dots and dashes, numbers and codes it was fed. Nothing in our data substantiated that babies were thermally stressed by *any* of the three bath procedures provided.

Were we frustrated!

A closer examination of the computer printout, however, did reveal something promising. One page was devoted to reporting on babies who responded with the least behavioral distress. These happier babies, having experienced all three bath techniques, showed the least crying and motor activity during the same one technique — regardless of the sequence of the procedures. The single technique yielding the unique data was the wrapped-bath procedure we had refined as a third option in our bath study.

Excitement returned to renew us. We pored over the data. Experiencing the technique we affectionately nicknamed the "cuddle bath," babies were described as exhibiting quiet contentment. Positioned face to face *(en face)* with their care-givers, some infants established eye contact with the adults right from the start and followed them with their eyes as the bath proceeded. Others cried initially but were obviously comforted as the procedure progressed. These babies seemed to *like* the cuddle bath. Admittedly, we did, too. Not only did it offer a change from routine, but the babies responded more positively to us as a result of it.

Back to the books and library shelves we scurried in an attempt to clarify our findings. We searched classic and current research suggesting that feeling is as fundamental to infants as food and that tactile and kinesthetic contacts have the greatest potential for stimulating responsive interaction in the newborn.[16,18] We were reminded that the warmth, cuddling, and en face positioning characteristics of the cuddle-bath technique are reinforcing to infants, often eliciting those responses that mothers have been found to highly value in the acquaintance process with their infants.[19] The attending responses of cuddle-bath babies reduced their crying and behavioral distress which is so disturbing to mothers. Mothers see such activity as rejection, which thereby inhibits further interaction between mother and child.[15,18]

In short, it didn't matter that none of the bath techniques demonstrated our hypothesized thermal stress of infants. While justifying the cuddle bath as harmless from this



The towel (still in sack to conserve warmth) is carried to the crib and the cuddle bath can start. Unrolling the towel downward, the author covers the undressed baby completely from his neck down. The baby almost smiles!



Unfolding the towel once, Marcia McCrary tucks half of it to one side. This is later used for the baby's back and head. Starting with one corner of the first half, the researcher bathes the infant in the usual sequence, starting with the face and working down.



Any soap (optional) is removed as she goes along, making sure to change the portions of the towel frequently. The en face position shown here is comfortable to use and allows the nurse to talk to the quiet baby and establish eye contact with him.

viewpoint, our data happily revealed babies to be enjoying bath time more when we cuddle bathed them, inviting us (and mothers everywhere) to enjoy it, too!

Implications for babies, mothers, and staff stimulated our imaginations:

- The technique appears safe — no thermal stress involved and no soap required (although it can be applied if needed or desired).
- It's efficient, less time-consuming, uncomplicated. New, tense mothers can learn to handle previously slippery and squalling babies more securely.
- It can be easily taught in hospitals, clinics, doctors' offices, and homes; it's inexpensive — no extra or unique supplies are needed.
- Above all, each mother can use bath time to learn more about her baby's responses amidst potentially less crying and behavioral distress. This encounter should encourage further positive mother-infant experiences during baths.

Although these implications indicate the great value of our findings, we're not finished yet. We've really only begun! Much needs to be clarified, researched, and refined. We feel that since our tool did not reveal thermal stress, another study is indicated to research this possibility. Our tool's design did not account for the fact that the motor activity involved in crying during a bath would significantly raise the infant's body temperature and thus counteract temperature loss through evaporation and exposure. Furthermore, thermal stress can be examined from many angles. We studied only body temperature. Drop in skin temperature, for instance, can yet be researched.

We are, however, pleased with our findings, and it seems that others are as well. The cuddle bath will be adopted by staff at our setting as soon as we complete a slide-tape demonstration which we are currently developing as a teaching tool for promoting this bath throughout our city and state. We have also presented a teleconference program—which was beamed from Tucson to Tempe and Prescott — in our efforts to share this discovery with peer-professionals. Already Kino Hospital in Tucson has requested inservice on this bathing technique which seems to suit the needs of the infant so well.

The newborn is coming into his own these days as a sensitive, aware person. We agree with LeBoyer that the trauma of the newborn is real.[18] To give comfort and pleasure to this tiny individual in need, as we feel have, is a delight!



As McCrary uncovers the baby's torso, she uses a dry blanket to cover him and opens it to cover more of his body as she progresses downward with the bath. The infant shown here is actually falling asleep!



McCrary now uses the reserved half of the towel for the baby's back and head. If he has lots of hair, the usual method for a shampoo is used instead.

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Practical Guide to Preventing Neonatal HEAT Loss

Heat Loss Mechanism	Sources of Heat Loss	Preventive Measures
Conduction	Infant placed on cold sheet, scale, table, X-ray plate, etc.	Place a warm blanket between the infant's body and the cold surface. Have warm blankets available, especially in the delivery room, where heat loss may be rapid and severe.
Convection	Cold delivery room or nursery	Keep heat in delivery rooms and nurseries adequate or provide infants with adequate protection from convective heat loss while they are in these areas.
	Drafts from air-conditioner vents, windows, doors	Arrange nursery to avoid placing infant in drafty areas.
	Administration of cold oxygen	Warm oxygen prior to administration.
	Transporting infants from delivery room to nursery through cold corridors	Place babies in prewarmed incubators to transport them from delivery room to nursery. If an incubator is not available, wrap the baby (whose skin has been thoroughly dried) in a thick, warm blanket before transferring him from the delivery room.
Radiation	Proximity of cold windows or walls	Avoid placing bassinets, radiant warmers, and incubators near cold outside walls and windows.
	Cold incubator walls	Some clinicians recommend placing a vented plastic (Plexiglass) shield around the baby inside the incubator. But this impedes rapid access to the infant. Two plastic oxyhoods placed over the baby in an isolette will also decrease heat loss by radiation.
Evaporation	Baby remains wet in delivery room	Dry the baby immediately after delivery with a warm blanket. Be sure to dry the baby's head well. *Never* leave an infant wrapped in a wet blanket. Then: 1) Wrap the infant in a warm, dry blanket before handing him to his parents in the delivery room to hold for a short while, or 2) Place the dry infant in a prewarmed incubator, or 3) Place the dry infant under a radiant warmer.
	Bathing procedure	*Do not* bathe the baby after delivery until his temperature has stabilized within the range of normal. Whenever bathing an infant, wash and dry only a small area at a time, keeping the rest of the infant's body covered.
	Solution (or wet soaks) applied to infant's skin	If a solution or soak must be applied, warm it prior to application and keep it warm during the procedure.
	Increased heat loss via the lungs of a tachypneic infant	Oxygen must always be warmed and humidified prior to administration.

Joann K. Williams/Jean Lancaster

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Idea Exchange

Francine LeBlanc, Anne Schultz

Close to 5,000 persons, running the full gamut of the lifespan, live in the area of rocky, south shore Nova Scotia near Pubnico. Until a few years ago, their health needs were met by one physician whose office was in Pubnico Head and one part-time public health nurse working out of nearby Yarmouth.

Contact between the two was minimal.

In 1973, the medical director and nursing supervisor of the Western Health Unit, Dr. V.K. Rideout and Irene Stafford, along with the practicing physican at Pubnico Head, Dr. A.M. Clark agreed to a new approach to serving the people of the area. A nursing office was established in the existing medical center, the nurse's area was adjusted to correspond to the medical practice area, and PHN Francine LeBlanc came to work full-time in the community.

The experiment has succeeded — thanks largely to the co-operative and professional attitude of everyone involved. In the three years that the program has been in operation there have been noticeable changes:

- There has been a definite increase in the demand for public health nursing services and acceptance of public health staff as part of the community.
- Besides regular public health duties, the public health nurse has taken over some of the doctors' duties, including physical assessment at well-baby clinics and immunization.
- Through the public health nurse and certified nursing assistant, physicians in the center have obtained an overall view of their patients as family members, and insight into the community organizations available to assist them in their practice.

Implementation

The idea of a coordinated service suits the Pubnico area well; the program provides a quality of care experienced by few communities in the province. Since it was introduced, services have expanded considerably and now include three physicians, Dr. Clark, Dr. Peter Loveridge, and Dr. Nicholas Mattinson, as well as Francine LeBlanc and Carolyn d'Eon, a certified nursing assistant. Both nursing personnel are bilingual, making it easier to serve both the French and English communities in the area.

Because the nursing office is immediately adjacent to that of the physician, continual referral and exchange of information is possible. This, in turn, provides immediate feedback on patients between doctor, public health nurse and nursing assistant. In addition to her regular duties, Francine LeBlanc has taken over some of the health care previously provided by the doctor, such as: physical assessment at well-baby clinics, general immunizations, selected home visits and individual family counselling. A physician is, however, always available for consultation and referral.

Physicians at the center have found that more time can be allocated to serious medical matters, since the public health nurse counsels patients on less serious problems. She, in turn, has more time to listen to patients — a definite advantage from a mental health viewpoint. Health problems that many patients feel the doctors are too busy to be bothered with, can now be discussed with the public health nurse, then referred and discussed with doctors as necessary.

Because she is community oriented, the public health nurse visits many people in the community whom the doctor would never see. She and the certified nursing assistant are also the major coordinators with outside agencies, making use of the wealth of knowledge and contacts that public health nursing staff have. Through these activities, doctors in the center have become more aware of the community and able to perceive the patient as a member of his family.

Communication within the center is excellent; the setup, according to Francine LeBlanc, is "one of the best she has experienced across Canada." All health staff share mutual files and equipment within the center. In the exchange of information and professional knowledge, the physician and staff can obtain a total family outlook rather than just individualized facts on their patients.

Although there is an increase in nursing care, the education aspects of public health nursing are not diminished. In fact, with more office and home visits, there is even more opportunity to discuss prevention and educational aspects.

Nutrition Services

Since 1973, the services of a public health nutritionist from Yarmouth have been incorporated into the center. Nutritionist Beverley Dagley visits the center twice a month for counselling of patients referred by the doctors or public health nurse, as well as handling normal requests for information. With a nutritionist at the center, there seems to be an increased awareness of prevention, and a definite demand for more nutritional services.

Conclusion

Morale and support in a situation such as this does not filter up, it filters down. The Pubnico organization offers encouragement to all who are skeptical about public health staff and physicians working side by side.

For doctors who are thinking of similar steps towards improving health services in their own community, Drs. Clark and Rideout offer the following advice:

- Get to know your local health unit director, supervisor of public health nurses, and all public health staff.
- See what they can do for you and what you, in turn, can offer them.
- Regard the public health nursing staff as professionals; that is what they are.
- Start slowly and work things out together step by step.
- Don't expect immediate results.

Programmed learning CARDIAC DEPRES

Eleanore Warkentin

Learning about the drugs that we as nurses give to patients is a must if we are to administer them safely. Knowledge of the pertinent physiology and pharmacological action of the drug is an essential part of our understanding of how the drug works, when and why it should be given, what is a therapeutically safe dose and what complications and side effects to expect. Such essential information bears review from time to time just to keep us on our toes. The following programmed learning module on one significant group of drugs — cardiac depressants — is designed to do just that.

Instructions

In programmed instruction, the student builds a structure of knowledge in steps. These steps are small units of information called frames. Most of the frames in this program ask you to write a response.

Immediately after writing a response, compare it with the correct answer on the right. A correct response is immediately confirmed and the point just learned is reinforced. If the answer is incorrect, you can determine immediately why the response was wrong. This eliminates the possibility of building knowledge on a faulty structure.

Use an overlay to cover the answers in the right hand column. After each response, slide the overlay down to expose the next answer.

Programmed instruction is designed to facilitate comprehension and retention through a self-teaching technique. This method of presenting facts in a simple fashion promotes retention through self-motivation and self-pacing.

Lidocaine

Cardiac depressants are used extensively in the management of patients with arrhythmias. The cardiac depressants to be discussed here include Lidocaine, Procainamide, Quinidine, and Dilantin.

Lidocaine, procainamide, quinidine, and dilantin can be classified as _____. **cardiac depressants**

Lidocaine, commonly known as Xylocaine, is a widely used local anaesthetic and antiarrhythmic agent.

Automaticity is a characteristic exhibited by pacemaker cells of the specialized conduction system. Automaticity is defined as a gradual process in which a spontaneous loss of diastolic potential occurs, reducing transmembrane resting potential levels to threshold levels. This leads to depolarization.

A spontaneous loss of diastolic potential is known as _____. **automaticity**

Excitability is a characteristic exhibited by myocardial muscle fibers, which require an external stimulus to initiate depolarization. The strength of the stimulus, necessary to reduce transmembrane resting potential to threshold level, defines the excitability of the cell.

Myocardial muscle fibers are _____, **excitable**
whereas pacemaker cells have the characteristic property of _____. **automaticity**

The major action of cardiac depressants is the ability of these drugs to decrease automaticity of the myocardium. Decreasing automaticity may result in decreased incidence of arrhythmias.

An antiarrhythmic, then, is a drug which decreases ectopic formation by decreasing myocardial _____. **automaticity**

Lidocaine acts by depressing Purkinje fiber automaticity. The drug does not appear to alter myocardial excitability.

Following lidocaine administration, Purkinje fiber automaticity is _____ **decreased**
(increased, decreased)
and myocardial excitability is unaltered.

An action potential records the sequence of rapid ionic changes occurring within the myocardial cell, during the processes of depolarization and repolarization.

The recording of intracellular ionic changes occurring with depolarization and repolarization, is known as an _____. **action potential**



Lidocaine decreases the action potential duration (APD) in both Purkinje and ventricular muscle fibers.

The APD in both Purkinje and ventricular muscle fibers is _____ by the action of lidocaine.
(increased, decreased)

decreased

The specific effects of lidocaine on the atrial muscle are unknown, and the drug is not recommended for the treatment of atrial arrhythmias.

Lidocaine is not recommended for the treatment of arrhythmias which are _____ in origin.
(atrial, ventricular)

atrial

Intervals of variable cellular excitability have been identified within the cardiac cycle, and are considered to be a function of the recovery time of muscle cell fibers. The effective refractory period (ERP) is defined as the time period that must elapse following a response, before a second propagated action potential can be initiated. Lidocaine significantly decreases the ERP of Purkinje fibers.

The ERP of Purkinje fibers is significantly _____ by lidocaine.
(increased, decreased)

decreased

When used in therapeutic doses, left ventricular end-diastolic pressure is minimally affected by lidocaine. Therefore, lidocaine produces little alteration in stroke volume or blood pressure in either the normal or failing heart.

Although large doses of lidocaine have been known to produce hypotension, lidocaine characteristically has a _____ incidence of adverse hemodynamic effects.
(high, low)

low

Lidocaine has minimal effect on the electrocardiogram, however excessive doses may do the following:

— accelerate sinus pacemaker
— increase or decrease PR interval
— prolong QRS interval
— prolong QT interval

When used in therapeutic doses, the effect of lidocaine on the EKG is _____.
(minimal, excessive)

minimal

Following completion of drug absorption, the time required to reduce serum concentration to 50%, is known as the half-life ($t^1/_2$) of the drug.

An understanding of the _____ of a drug is essential in order to achieve a therapeutic patient response to the dosage schedule.

half-life or $t^1/_2$

Lidocaine is known to be a desirable antiarrhythmic agent because of its short half-life, which is less than two hours. This helps in establishing and maintaining therapeutic blood levels, as well as allowing dose titration according to ectopic activity.

The $t^1/_2$ of lidocaine is less than _____ hours.

two

The half-life of lidocaine is dependent upon adequate liver function. Lidocaine is hydrolyzed by the liver to para-aminobenzoic acid, which is then excreted in the urine. Less than 10% of the drug is excreted unaltered by the kidney.

The organ responsible for the metabolism of lidocaine is the _____.

liver

Lidocaine is, therefore, administered with caution to patients with liver, renal and/or cardiac failure.

In summary, then, properties such as minimal EKG effects, a low incidence of adverse hemodynamic effects, and a short half-life, make lidocaine a/an _____ drug for the therapeutic treatment of acute arrhythmias.
(desirable, undesirable)

desirable

Absorption of lidocaine from the gastrointestinal tract is irregular, resulting in unreliable drug action. Oral preparations of the drug are not presently available in Canada.

The difficulty in achieving reliable blood levels with oral lidocaine therapy, is likely a direct result of its _____ absorption from the G.I. tract.
(regular, irregular)

irregular

Lidocaine may be administered intramuscularly or intravenously. When injected intramuscularly, the drug is rapidly absorbed and therapeutic blood levels are present in 10 - 15 minutes, lasting approximately two hours. Despite this, the use of intramuscular lidocaine is restricted to those situations in which intravenous infusion is impractical.

Therapeutic blood levels of lidocaine are present in _____ to _____ minutes after intramuscular drug injection. **10 - 15**

In the critically ill patient who develops an acute ventricular arrhythmia, a continuous intravenous infusion of lidocaine is preceded by a loading or "bolus" dose, in order to achieve an immediate blood level. The loading dose is administered directly into the intravenous line over a 30 - 60 second time period.

A loading dose of lidocaine is administered in order to achieve an _____ blood level. **immediate**

An adequate loading dose for the average adult is 50-75 mg. (or 1 - 2 mg/kg)*. This may be repeated every five minutes until either ectopics are abolished or a total dose of 150 mg has been given.

The usual initial loading dose of lidocaine is _____ to _____ mg in the average adult. **50 - 75**

A continuous intravenous infusion of lidocaine, via intravenous drip or preferably, via an infusion pump, is established to maintain a therapeutic blood level when clinical evidence of ventricular irritability exists. The drug should be infused at a rate of 1 - 3 mg/kg/hour until irritability subsides, resulting in a therapeutic serum level of 2 to 5 mcg/ml.

The continuous infusion rate of lidocaine is usually _____ to _____ mg/kg/hour in the adult patient. **1 - 3**

Following abolition of ventricular rhythm disturbances, the lidocaine infusion is gradually discontinued. Patient monitoring for recurrent rhythm disturbances is essential during this time, as well as throughout the entire course of lidocaine therapy.

The principal toxic effects of lidocaine are extracardiac. A frequently observed adverse effect is drowsiness. Toxic effects can include muscular twitching, irritability, hallucinations, and generalized convulsions. Cardiac effects such as hypotension and rhythm disturbances are rarely seen.

The most frequently observed adverse effect of lidocaine is _____. **drowsiness**

Toxic effects of lidocaine resolve rapidly because of the drug's short half-life. Treatment of toxicity, therefore, consists simply of supportive care until the drug has been metabolized.

Lidocaine, then, is the drug of choice in the treatment of ventricular ectopics. Rhythm disturbances, due to discharge of irritable ventricular foci, may appear in EKG as unifocal PVC's, multifocal PVC's or ventricular bigeminy and trigeminy.

Rhythm disturbances resulting from the premature depolarization of ventricular muscle fibers should be treated with _____ in order to prevent the development of lethal arrhythmias such as ventricular tachycardia and ventricular fibrillation. **lidocaine**

Lidocaine has been used successfully to treat digitalis-induced arrhythmias of atrial and/or ventricular origin.

Ventricular escape beats are *not* treated with lidocaine. A ventricular escape beat is a myocardial response to decreased cardiac output. In relation to the previous cardiac cycle, the ventricular ectopic occurs late (rather than premature), and usually follows a pause in basic cardiac rhythm.

In summary, _____ is the antiarrhythmic used in the treatment of any rhythm disturbances caused by premature discharge of an irritable ventricular focus. **lidocaine**

Procainamide

Procainamide, also known as Pronestyl, is a cardiac depressant with local anesthetic and cardiac properties similar to those of lidocaine.

Procainamide, like other cardiac depressants decreases myocardial automaticity. Pronestyl also decreases myocardial excitability by raising stimulation and fibrillation thresholds on atrial and ventricular muscle fiber.

The effect of pronestyl on both atrial and ventricular muscle is to _____ (increase, decrease) **decrease**

automaticity and to _____ (increase, decrease) **decrease**

cellular excitability.

Procainamide is a more potent suppressant of cardiac conduction than is lidocaine. Pronestyl decreases conduction velocity significantly in the atria, but also in Purkinje and ventricular muscle fibers. This may be recognized on EKG by prolonged PR, QRS and QT intervals.

Pronestyl therapy has been known to _____ (increase, decrease) **increase**

atrioventricular conduction time, and thus should not be used in the presence of AV block.

Procainamide also has a vagal-inhibiting effect, this possibly resulting in enhanced atrioventricular conduction. Therapeutic doses of digitalis inhibit this effect.

A paradoxic increase in cardiac rate may be seen because the drug blocks or _____ (inhibits, stimulates) **inhibits**

the vagus.

Procainamide may produce myocardial tachycardia and/or fibrillation. This is probably because it increases action potential duration as well as the

*Drug dosages used in "Programmed Learning: Cardiac Depressants" are specific to Health Sciences Centre, Winnipeg, Manitoba.

effective refractory period. This effect is seen to a greater extent in the atria than in the ventricle.

Procainamide _____ (increases, decreases) both refractory time and action potential duration, this effect being more evident in the _____ (atrial, ventricular) myocardium.

increases

atrial

The action of pronestyl on ERP and APD is _____ (similar, opposite) to that of lidocaine.

opposite

Procainamide may decrease left ventricular function, leading to an increase in left ventricular end-diastolic pressure and a significant decrease in cardiac output. This occurs more often in the patient with existing myocardial damage and is usually associated with intravenous drug therapy.

Pronestyl therapy may be complicated by hypotension, because of its effect of decreasing _____. Comparable doses of lidocaine do not have this effect.

cardiac output

Procainamide may be given orally, intramuscularly, or intravenously. Pronestyl is readily absorbed from the G.I. tract. Management of arrhythmias with procainamide therapy is preferably achieved with oral dosage of 500 - 1000 mg every six hours.

Usual oral dosage of pronestyl is _____ to _____ mg. every six hours, maximal absorption occurring in approximately 1½ hours.

500 - 1000

When administered intramuscularly or intravenously, significant blood levels are present in 15 minutes. Due to adverse hemodynamic effects of giving pronestyl parenterally, however, these routes of administration are reserved for life-endangering cases or when the arrhythmia is refractory to lidocaine therapy. Average intravenous dose is 150 - 300 mg/kg/hour.

Procainamide is preferably administered by the _____ (oral, I.M., I.V.) route.

oral

Because of its half-life of 3½ hours, procainamide has a longer duration of action than does lidocaine.

Pronestyl, in contrast to lidocaine, has a _____ (shorter, longer) duration of action.

longer

Plasma levels of 3 - 8 mcg/ml are usually effective in controlling atrial and ventricular arrhythmias. Toxic effects are seen when serum drug levels exceed this range.

Therapeutic serum pronestyl levels are in the range of _____ to _____ mcg/ml.

3 - 8

Metabolism of procainamide takes place in the liver, however 60% of the drug is excreted unaltered in the urine. A higher incidence of toxicity, due to drug accumulation, is associated with poor renal function.

Careful monitoring of serum levels, particularly in the patient with inadequate renal function, will help prevent drug _____.

toxicity

With oral pronestyl administration, the most frequent untoward effects observed are anorexia, nausea, and vomiting.

Frequent side effects following oral pronestyl therapy include _____, _____, and _____

anorexia, nausea, vomiting

Cardiac side effects of procainamide, as mentioned above, may include hypotension and occasionally, shock. Paradoxic increases in cardiac rate may occur, as well as the appearance of escape and ectopic ventricular arrhythmias.

Hypotension, a complication of pronestyl therapy, is seen more frequently when the drug is given via the _____ (oral, I.M., I.V.) route.

I.V.

Because of this, the drug should be infused slowly, with continuous EKG and BP monitoring.

Toxic extra-cardiac effects that may be observed include somnolence, hallucinations, convulsions and occasionally coma, due to anaesthetic properties of the drug. Agranulocytosis, severe anemia and thrombocytopenia have been reported, and usually subside spontaneously. Hypersensitivity reactions have also been observed.

Extra-cardiac toxic effects of procainamide therapy include _____

CNS disturbances. blood dyscrasias hypersensitivity reactions

Drug infusion is discontinued when the arrhythmia subsides, with excessive widening of the QRS complex, or with the development of myocardial toxicity symptomatology.

Management of procainamide toxicity consists of discontinuing drug therapy and initiating supportive therapy. eg. blood pressure elevation.

In summary then, procainamide is used to manage difficult and/or dangerous arrhythmias.

Procainamide is used orally, usually in conjunction with digitalis, to suppress atrial arrhythmias such as atrial fibrillation and paroxysmal atrial tachycardia. It will convert atrial fibrillation to sinus rhythm, but will merely slow the atrial rate of an atrial flutter rhythm.

A drug frequently used, in conjunction with procainamide to suppress atrial arrhythmias is _____.

digitalis

Arrhythmias of junctional or ventricular origin, such as premature systoles, ventricular tachycardias, and other life threatening arrhythmias, may also be managed with intravenous procainamide.

Arrhythmias of junctional or ventricular origin, when

unresponsive to lidocaine therapy, may be managed with _____. **pronestyl**

The effect of procainamide therapy on digitalis-induced arrhythmias can be unpredictable.

Quinidine

Quinidine is a myocardial depressant with antiarrhythmic actions similar to those of procainamide.

Quinidine, like procainamide, decreases myocardial automaticity throughout the atrial and ventricular myocardium, and is therefore used clinically to prevent and control both atrial and ventricular arrhythmias.

Quinidine and procainamide are utilized in the management of both atrial and ventricular arrhythmias because of their action of _____. **decreasing myocardial automaticity**

Quinidine depresses excitability, conduction velocity and contractility properties of cardiac muscle.

Excitability of cardiac muscle is depressed by quinidine because the drug increases the stimulation threshold of the muscle cells. This may be recognized clinically, when following quinidine administration, the energy required to produce atrial and ventricular stimulation is increased.

A drug which increases stimulation threshold makes it _____ (more, less) **more**
difficult to excite or stimulate the muscle cell.

Reentry ectopics occur at fixed coupling intervals to the preceeding impulse. This can occur whenever two areas of uneven conduction exist (one area is ischemic), in adjacent myocardial fibers. The result is an initial normally conducted impulse (A), followed at a fixed interval, by an abnormally conducted impulse (B) occurring after the ischemic area has recovered, and been reentered by the initial impulse.

The antiarrhythmic properties of quinidine are based on the drug's ability to increase action potential duration and increase the effective refractory period. This action is useful in managing ectopic impulses occurring due to a reentry mechanism.

The incidence of ectopic impulses due to a reentry mechanism, is _____ (increased, decreased) **decreased**
when treated with quinidine and/or procainamide.

Quinidine increases the conduction time in atrial, Purkinje and ventricular muscle fibers. Quinidine's action of increasing refractory time may be recognized clinically by the appearance of prolonged QRS and QT intervals, sinus bradycardia and prolonged AV conduction.

The direct action of quinidine on the heart's conduction may be observed by _____ (shortened, prolonged) **prolonged**
QRS and QT intervals and by the appearance of sinus bradycardia and _____ (shortened, prolonged) **prolonged**
AV conduction.

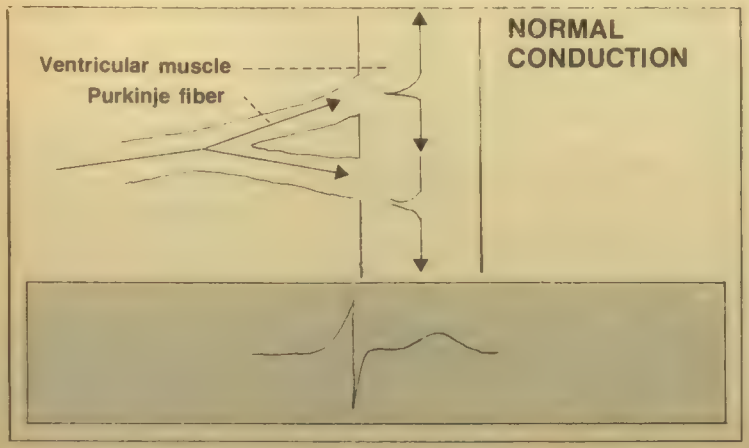
Quinidine is a general cardiac depressant and may reduce stroke volume and cardiac output. This leads to an increased left ventricular end-diastolic pressure. Clinical manifestations of decreased cardiac output such as hypotension then become evident.

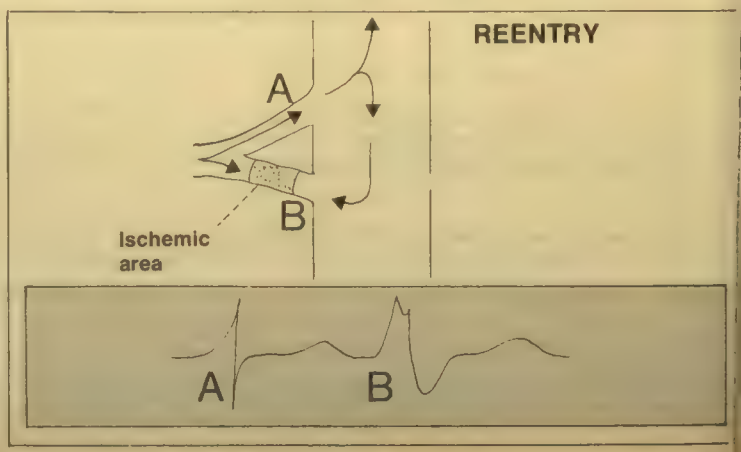
Reduced myocardial efficiency, secondary to quinidine therapy, may be manifested by an _____ (increased, decreased) **increased**
left ventricular end-diastolic pressure.

Quinidine is an effective, yet dangerous myocardial depressant. The severe hypotension, due to quinidine's adverse effect on myocardial contractility, is most often seen with intravenous drug administration. Astute clinical patient assessment is mandatory whenever quinidine is used, regardless of mode of administration.

Severe hypotension, secondary to quinidine therapy, is seen most often after _____ (oral, I.M., I.V.) **I.V.**
administration of quinidine.

Both quinidine and procainamide have a vagal inhibiting effect, that is, they inhibit vagal





innervation. Adequate digitalization is essential prior to initiating quinidine therapy for control of atrial arrhythmias. Quinidine, when used without digoxin and in small doses, may actually improve atrioventricular conduction. This may be an adverse response, allowing the ventricle to respond on a 1:1 basis to the rapid atrial activity.

Prior to commencing quinidine therapy, the physician should ensure adequate patient _____. **digitalization**

Idiosynchratic responses to quinidine are frequent, therefore an initial test dose of the drug should be administered. Symptoms of such an immunological response include confusion, dizziness, headache, syncope, visual disturbances, skin rash, and generalized muscle weakness.

Prior to administering therapeutic doses of quinidine, a _____ is always administered. **test dose**

Quinidine is usually administered orally, and occasionally intramuscularly. It is rapidly absorbed from both these routes.

Dosage range for oral administration, following a test dose of 200 mg, is 200 - 600 mg every six hours. The dose is increased daily according to patient need and tolerance. Maximal absorption after oral administration occurs in 1-2 hours, the half-life being approximately 4-6 hours.

Following oral administration of quinidine, therapeutic effects of the drug may be observed as long as _____ to _____ hours after instituting drug therapy. **4 - 6**

Intramuscular administration of quinidine is chosen whenever the oral route is contraindicated. The intramuscular test dose is usually 100 mg, followed by 200 mg given every six hours. The dose may be increased up to 400 mg q6h depending on desired patient response and patient tolerance.

Usual dose of intramuscular quinidine is _____ to _____ mg every six hours. **200 - 400**

The most common toxic manifestations following quinidine therapy are gastro-intestinal. Diarrhea, nausea and vomiting are relatively common, and when mild, are not a contraindication to therapy.

Mild diarrhea, nausea and vomiting _____ (are, are not) an indication to discontinue quinidine therapy. **are not**

Signs of cardiovascular toxicity may include repetitive ventricular extrasystoles, runs of ventricular tachycardia and rarely, intermittent ventricular fibrillation. Hypotension may be a precursor of, or accompany EKG signs of toxicity such as abnormally prolonged PR, QRS, and QT intervals and bundle branch block.

Signs of cardiovascular toxicity, secondary to quinidine therapy include rhythm disturbances which originate in the _____ (atria, ventricle). **ventricle**

and EKG signs of toxicity such as prolonged _____, _____, and _____ intervals, as well as bundle branch block. **PR, QRS, QT**

Idiosyncratic immune responses to quinidine have been discussed briefly. More serious hypersensitivity reactions known to occur are respiratory embarrassment, vascular collapse, and convulsions, necessitating appropriate resuscitative measures.

Uncertainty in individual patient response requires caution when initially administering quinidine. Because of this a _____ of the drug is always administered prior to initiating aggressive drug therapy. **test dose**

Quinidine is used with extreme caution when any degree of block exists, or when hypotension or congestive heart failure are present. Quinidine is not used to treat digitalis intoxication.

Contraindications to quinidine therapy include _____, _____ and _____. **heart block, hypotension, congestive heart failure**

On occasion patients with arrhythmias and CHF have to be treated with quinidine. These patients are usually also receiving digitalis, to ensure adequate contractility. The depressant effects of quinidine on myocardial contractility indicate that the drug must be used with caution in these patients.

Quinidine is a cardiac depressant, frequently used in conjunction with digitalis, in the treatment and/or prophylaxis of sustained atrial ectopic rhythms such as atrial tachycardia, flutter and fibrillation. It is also used to control ventricular rhythm disorders that have been found to be unresponsive to lidocaine and procaine therapy.

When used to treat sustained atrial ectopic rhythms, quinidine is always used in conjunction with _____. **digitalis**

Although lidocaine remains the drug of choice for treating most ventricular arrhythmias, quinidine has been used with success in ventricular rhythm disorders that have been found to be _____ to lidocaine therapy. **unresponsive**

In the liver, 80% of quinidine is metabolized, with approximately 20% being excreted unaltered in the urine. Serum quinidine levels are useful to monitor drug levels, particularly in patients with congestive heart failure or renal insufficiency. The therapeutic range for serum quinidine levels is 3 - 8 mcg/ml, toxic symptomatology occurring with increased frequency above this level.

The therapeutic range for serum quinidine levels is _____ to _____ mcg/ml. **3 -8**

Ventricular fibrillation and syncope have, however, been reported at quinidine levels within the therapeutic range, therefore careful clinical

assessment of the patient and EKG monitoring is essential to recognize early signs of toxicity and prevent serious resulting complications.

Toxic manifestations, secondary to prolonged quinidine therapy, may be of 24 - 48 hours duration.

Diphenylhydantoin

Diphenylhydantoin, or dilantin, is a non-sedative anticonvulsant drug, which has been used with increasing frequency to control rhythm disturbances caused by digitalis intoxication.

The antiarrhythmic actions of dilantin are most similar to those of lidocaine, and can, in some areas, be contrasted with the actions of pronestyl and quinidine.

Dilantin and lidocaine have _____ (similar, opposite) antiarrhythmic actions. **similar**

Dilantin is comparable to other cardiac depressants in that it decreases myocardial automaticity by directly depressing diastolic depolarization. This effect is particularly evident in the Purkinje fibers, even with small doses, and is thought to be responsible for the successful reversion of ventricular ectopic rhythms occurring in digitalis-intoxicated hearts. A similar depressant effect can be observed in the SA node, when large doses of dilantin are utilized.

Even when used in small doses, the depressant effect of dilantin on diastolic depolarization is particularly evident in the _____ (atrial, Purkinje) fibers. **Purkinje**

Diphenylhydantoin, like lidocaine, does not appear to significantly alter myocardial excitability.

Both dilantin and lidocaine _____ (increase, decrease) automaticity, but do not appreciably alter _____. **decrease** **excitability**

Dilantin decreases both action potential duration and the effective refractory period. This can be recognized on EKG by a shortened QT interval.

A shortened QT interval is a manifestation of dilantin's action of _____ (increasing, decreasing) both APD and ERP. **decreasing**

The effect of dilantin of APD and ERP is _____ (similar, in contrast) to that of lidocaine, and _____ (similar, in contrast) to that of procainamide and quinidine. **similar** **in contrast**

Diphenylhydantoin does not prolong intraventricular conduction, even when used in very large doses. This is again in contrast to the actions of pronestyl and quinidine. Dilantin, by reducing the chance of impaired conduction, as well as by increasing membrane responsiveness in Purkinje fibers, is useful in managing reentrant rhythms.

Dilantin is useful in the management of _____ rhythms, due to intraventricular conduction disorders. **reentrant**

Dilantin tends to shorten the PR interval, although it is not thought to have any significant vagal-inhibiting effect.

Dilantin therapy has minimal EKG effects. Changes which may be observed include _____ (shortened, prolonged) PR and QT intervals. **shortened**

Dilantin causes less depression of myocardial contractility, than do comparable antiarrhythmic concentrations of quinidine and pronestyl. Arterial pressure reductions also occur less frequently with dilantin therapy, but hypotension may be associated with the rapid infusion of any of the myocardial depressants studied thus far.

Of the cardiac depressants studied thus far, the two which significantly alter contractility and arterial pressure are _____ and _____. **procainamide & quinidine**

Diphenylhydantoin is almost completely inactivated by the liver, and is closely bound to plasma proteins. Less than 5% of the drug is excreted unmetabolized in the urine.

Reduced doses of dilantin are necessary when the drug is given to patients with _____ disorders. **liver**

Because of its long half-life, approximately 24 hours, and slow absorption, a single daily dose is often satisfactory for adults. Gastric intolerance, however, may dictate divided dosage or at least indicate meal time administration to minimize GI disturbances.

The half-life of diphenylhydantoin is approximately _____ hours. **24**

Dilantin may be given orally, intramuscularly or intravenously. A loading dose of approximately 200 mg is frequently given, since it may take several days to achieve a therapeutic blood level.

To facilitate rapid achievement of therapeutic blood levels, an initial _____ of dilantin is often administered. **loading dose**

Oral administration, used in the control of cardiac rhythm disorders, consists of giving 100 - 150 mg of dilantin (3 - 4 mg/kg) twice or three times daily.

In order to achieve control of cardiac rhythm disorders, _____ to _____ mg of oral dilantin is given two or three times a day. **100 - 150**

Intramuscular drug doses are comparable to those listed for oral therapy. Following intramuscular injection, the drug tends to precipitate at the injection site and is absorbed slowly.

Dilantin is given intravenously when rapid effects are necessary to treat acute arrhythmias. A slow injection of 50 - 100 mg of dilantin is given initially. This dose may be repeated twice, at ten minute intervals, to achieve acute rhythm stabilization. Maximum adult dose should not exceed 10 - 15 mg/kg. Continuous dilantin infusions are not recommended.

Dilantin is administered _____ (orally, I.M., I.V.) **I.V.**
to treat acute arrhythmias.

Therapeutic serum dilantin levels are in the range of 10 - 18 mcg/ml. These levels are achieved by regular, intermittent administrations of the drug.

The therapeutic serum dilantin level is _____ to _____ mcg/ml. **10 - 18**

Cardiac effects of dilantin toxicity include hypotension, severe bradycardia, ventricular arrhythmias and cardiac arrest.

Cardiovascular manifestations of drug toxicity include _____ **hypotension, bradycardia, ventricular arrhythmias, cardiac arrest.**

The most consistent effect of dilantin intoxication is manifested by CNS disorders. Signs such as nystagmus, diplopia, and vertigo are seen, as well as behavioural disorders such as confusion, silliness, drowsiness, hyperactivity and hallucinations.

A frequent indication of an overdose of dilantin is some type of _____ disorder. **CNS**

Hypersensitivity reactions to the drug are indicated by the following:

— skin eruptions
— exfoliative dermatitis
— bone marrow depression

Skin eruptions, dermatitis, and bone marrow depression are signs of hypersensitivity reactions to _____. **dilantin**

Treatment of dilantin toxicity consists of supportive therapy, since there is no specific antidote available. Toxic manifestations may persist for hours or days, because of the drug's long half-life.

Diphenylhydantoin is particularly effective when used to manage digitalis-induced ventricular arrhythmias. It has been used with some success to treat atrial and junctional arrhythmias, secondary to digitalis toxicity, but has little effect in atrial flutter or atrial fibrillation. As well, dilantin is useful in treating ventricular arrhythmias, whether or not they result from digitalis intoxication.

In summary, then, dilantin is considered to be the drug of choice to manage _____ (atrial, ventricular) **ventricular**
rhythm disorders secondary to digitalis intoxication.

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A new look at blood transfusion therapy

AUTOTRANSFUSION

Be your own blood donor! That's the word from St. Joseph's Hospital in Hamilton, Ontario to those who are about to undergo elective surgery. Using a simple, safe procedure known as autotransfusion phlebotomy, the inherent risks involved in transfusion therapy are minimized and greater patient safety is achieved. What follows is a history and description of St. Joseph's autotransfusion program and how you could initiate it in your hospital.

Margaret Anne Halward

The traditional administration of blood transfusions from one person to another will always carry the risks of incompatibility reactions, antibody formation and transmission of disease. Moreover, it is becoming increasingly difficult to attract suitable blood donors to meet today's increasing needs. Autotransfusion can completely avoid these problems when used before elective surgery.

Autotransfusion of the type I will describe was first reported by Dr. Francis Grant to the Philadelphia Academy in 1921.[1] The full potential of autotransfusion has been gradually recognized within the last few years and several centers in the United States have reported considerable success with autotransfusion programs.

The autotransfusion program at St. Joseph's Hospital was begun by a group of physicians who were interested in making transfusion therapy safer for patients. One of those physicians was Dr. G.K. Ingham who became the Program Director. The well-structured administrative and technical procedures for the program were established by Helen Eaton, R.N., Head Nurse of I.V. and Blood Collection Team (1971-1974) and John Waller, Methods Analyst from our Methods Department. The necessary cooperation of the surgeons, the Out Patient Department, the Blood Bank, the I.V. and Blood Collection Team and the Admitting Department was also secured. Contact was made at this time with the other hospitals in Hamilton, so that patients having surgery in any of these hospitals could also receive the benefits of autotransfusion.

MRS. B.'s SCHEDULE **Figure 1**

Date of arrival in OPD	Stage	Procedure	Time Involved
April 7 0930 hours	First stage autotransfusion phlebotomy	— collect one unit of Mrs. B.'s blood	30 minutes
April 14 0930 hours	Second stage autotransfusion phlebotomy	— collect one unit of Mrs. B.'s blood — return April 7th unit of blood to her by infusion — collect a second unit of Mrs. B.'s blood	2- 2 1/2 hours
April 21 0930 hours	Third stage autotransfusion phlebotomy	— collect one unit of Mrs. B.'s blood — return first unit from April 14 to her by infusion — remove a second unit of Mrs. B.'s blood — return the second unit of blood from April 14 to her by infusion — remove a third unit of blood	2 1/2- 3 hours
April 28	Mrs. B.'s O.R. day	— 3 units of blood, 1 week old, are on hand to be infused during or after Mrs. B.'s surgery.	

The Program

Briefly, the autotransfusion program consists of the collection of up to three units of a patient's blood over a one, two or three week period just prior to the date of that patient's elective surgery. The estimated number of units required for the patient during surgery determines how far in advance the patient will donate blood. For example, if one unit of blood is required, the patient will donate one unit of blood one week prior to surgery and hence it would be stored for one week at time of surgery.

When more than one unit of blood is required, a recycling maneuver is used in order to minimize the known deterioration of red blood cells during storage, a deterioration which is especially marked after one week. Thus, if 2 units are required, the patient will donate one unit of blood 2 weeks (14 days) prior to surgery. Seven days later, the patient donates a second unit of blood, the first unit is infused back into the patient, and a third unit of blood is removed. This provides a net of 2 units of blood, both of which, at the time of surgery, will have been stored for one week. If 3 units are required, a further projection of this recycling process results in a net of 3 units, all of which have been stored one week, at the time of surgery. Even 4 units of blood can be secured this way under special circumstances. Again, in this case, all of the 4 units of blood will be only a week "old" at the time of the operation.

There are no specific contraindications fo participation in the autotransfusion program The only stipulation is the ability to tolerate the removal of one or two units of blood.

Case study

The best way to illustrate exactly how th autotransfusion program works is to follow patient's progress through the program.

Mrs. B., a 28-year-old female, is having laminectomy and spinal fusion on April 28t

In February, Dr. A., Mrs. B.'s Orthoped Surgeon, tells her about her back surgery ar states he would like three units of her blood o hand for her surgery in April. The autotransfusion program is explained to Mr B. She is very positive about having the autotransfusions as most of our patients are At this time, Dr. A. sends an Autotransfusio Request Form to the Head Nurse of the I.V and Blood Collection Team.

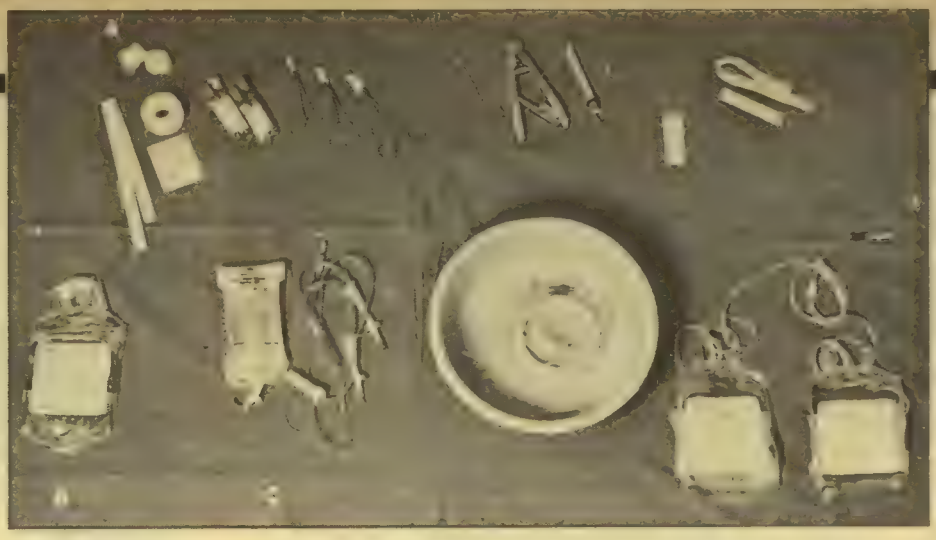


Figure 2

A. Basic equipment (required for all autotransfusions) — specimen tubes, adhesive tape, tourniquet, antiseptic swab, blood donor scales, scissors, blood tubing clips and clamp, Kelly forceps, identification bracelet, identification numbers, and a file.

B. First stage autotransfusion phlebotomy
— single donor pack

C. Second stage autotransfusion phlebotomy
— double plasmaphoresis double donor pack
— blood warming coils
— basin and thermometer
— Y-type recipient set
— 250 cc bag of Normal Saline
— an I.V. pole (not shown)

B. & C. Third stage autotransfusion phlebotomy
— combination of both the equipment used for a first and second stage autotransfusion.

Fourth stage autotransfusion phlebotomy
— 2 double plasmaphoresis double donor packs
— an I.V. pole
— blood warming coils
— basin and thermometer
— Y-type recipient set
— 2 bags 250 cc Normal Saline.

The Head Nurse schedules Mrs. B.'s procedures (see Figure 1) and notifies her of the schedule by phone and letter. Copies of this notification letter are also sent to Dr. A., Mrs. B.'s family physician, the Blood Bank, the O.P.D. Department, and the I.V. and Blood Collection Team.

Prior to Mrs. B.'s visits, a file is set up for her containing the following:

- Dr. A.'s Autotransfusion Request Form
- Mrs. B.'s notification letter
- a recording sheet for the autotransfusion procedures
- a laboratory requisition for bloodwork taken during the procedures.

On completion of the procedures, the file is sent to the admitting department of the particular hospital where the surgery is to be done and becomes part of Mrs. B.'s permanent chart when she is admitted to that hospital.

First stage autotransfusion phlebotomy

Mrs. B. arrives on April 7th, in the Out Patient Department as scheduled for her first procedure. She is made comfortable in one of the treatment rooms on either a stretcher or a lazy-boy chair by the nurse in our Out Patient Department. The nurse checks and records Mrs. B.'s blood pressure, pulse, weight, and notifies the program director, Dr. Ingham, and an I.V. nurse of the patient's arrival.

Dr. Ingham interviews Mrs. B. and does a brief physical examination, gives Mrs. B. a prescription for iron tablets which are taken throughout the course of the procedures, and explains all of the autotransfusion procedures to her. It is important that she understands all of the procedures and has all of her questions answered to alleviate any apprehension she may have. Dr. Ingham will also see Mrs. B. prior to all of her visits, and remains available during the procedures if problems arise.

An identification bracelet is given to her to wear on her wrist during all of the procedures and during her hospitalization. It states her full name, the name of the program director and identification number which is placed on her file and on all the units of blood she donates.

All the autotransfusion procedures are performed by a registered nurse who is a member of the I.V. Team. In our hospital, all of the nurses on the I.V. Team have been specially trained to do these procedures and it is part of their daily assignment.

The equipment is made ready, using all the basic equipment plus a donor pack as seen in Figure 2. After explaining the procedure, the I.V. nurse applies a tourniquet, selects a large vein in the antecubital fossa of Mrs. B.'s arm, preps the site with an antiseptic, inserts the 15 gauge needle as pre-attached to the donor pack, and removes one unit (approximately 500 cc) of Mrs. B.'s blood (see Figure 3). When this is completed, the nurse calls a blood bank technician who clamps off and cuts the unit of blood from the needle, attaches the identification numbers to Mrs. B.'s bracelet, file and unit of blood and then takes the unit of blood back to the Blood Bank where it is refrigerated until next week's procedure. Blood specimens are taken from the same needle for a complete blood count, VDRL, Australian Antigen and serum ferritin level. On Mrs. B.'s second and third stage autotransfusion phlebotomies, only complete blood counts will be done.

Once the blood specimens are taken, the needle is removed and pressure applied to the site until there is no further bleeding.

Following autotransfusion phlebotomy, Mrs. B.'s blood pressure and pulse are checked by an Out Patient Department nurse until they are stable. She is given a warm drink and may go home as soon as she feels settled.

Second stage autotransfusion phlebotomy

Mrs. B.'s second visit to the Out Patient Department includes the same care as outlined for the first stage autotransfusion phlebotomy. For this procedure, a double plasmaphoresis double donor pack set is used (See Figure 4). This contains one needle with three connectors. A blood donor pack is attached to the first connector and clamped off



Figure 3

Mrs. B. having a first stage autotransfusion phlebotomy where one unit of blood is collected.

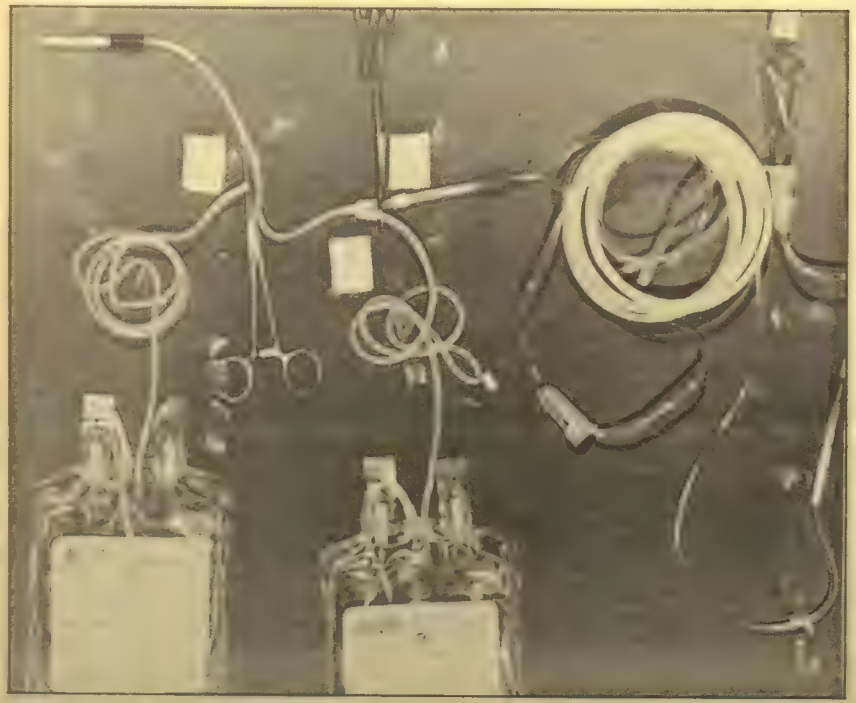


Figure 4

Double plasmaphoresis double donor pack set.

Figure 5

A second stage autotransfusion phlebotomy — close-up of the blood bank technician clamping of the first unit of blood removed during today's procedure.



with a Kelly forcep. The second connector i attached to a 250 cc bag of Normal Saline which has flushed through the Y-type recipien set and the blood warming coils. The coils function to increase the temperature of the cold infusing blood to body temperature. It too is then clamped off with a Kelly forcep. The third connector, already attached to a dono pack, remains ready for use. A venipuncture i done in Mrs. B.'s left arm and the first unit o blood is collected in this pack. The I.V. nurs calls the blood bank technician who brings Mrs. B.'s unit of blood collected at the first stage procedure one week ago. The technician clamps off and cuts from the needl the first unit of blood removed in today's procedure (See Figure 5). This unit is then placed in the Blood Bank refrigerator for storage.

The I.V. nurse now unclamps the connection leading to the Normal Saline ar flushes the entire tubing. The unit of blood removed from the patient during her first stag autotransfusion phlebotomy is checked an plugged into the second Y-connector of the recipient set; the warming coils are placed in basin of water (36.5° C — 37° C); the Norm Saline is shut off and the blood is infused ov a 15-20 minute period (see Figure 6). Following this, the Normal Saline is again us to flush all the tubing and is then clamped. Th second donor pack is unclamped and a second unit of blood is collected. It is then sealed, cut off from the needle, and



Figure 6 *A second stage autotransfusion phlebotomy. The I V. nurse adjusts the rate of flow of Mrs B 's blood taken during the first stage procedure. The blood is being reinfused through the Y-type recipient set and the warming coils.*



refrigerated in the Blood Bank along with the first unit until the next week's procedure.

Third stage autotransfusion phlebotomy

Mrs. B.'s third stage autotransfusion phlebotomy occurs on April 21st, her pre-care and equipment set up just as it was for her second stage autotransfusion. The second stage procedure is repeated and includes the infusion of the second unit of blood removed the previous week. Mrs. B. has another venipuncture (usually the opposite arm) to remove the third unit of blood and once her post-care is done, the autotransfusion program is complete.

The Blood Bank now has 3 units of blood on hand collected on the 21st of April for her surgery on April 28th. Mrs. B.'s hemoglobin is 11 gms after her procedures, and this is reported to the orthopedic surgeon along with the exact amount of blood collected. When the blood is needed by the patient in the operating room or after surgery, the blood is sent from the Blood Bank and infused into the patient. If the surgery is performed at another hospital, the blood is transferred from our Blood Bank to the other hospital on the day before scheduled surgery.

If a fourth stage autotransfusion is requested by her doctor, the patient follows the same procedure through the first, second and third stages of autotransfusion phlebotomy. Then, for the fourth stage, the entire second stage autotransfusion phlebotomy is done in one arm and is then repeated, usually in the opposite arm. The units of blood removed from the patient during her third stage autotransfusion phlebotomy will be returned to the patient during this procedure.

Discussion

Mrs. B. is just one example of over 225 patients who have had up to four stages of autotransfusion phlebotomy done since the program was initiated in 1972. Operative procedures of patients who have utilized the autotransfusion program have been varied, e.g. total hip replacement, Harrington's Procedure, laminectomy and spinal fusion, bilateral reduction mammoplasty, abdominal hysterectomy, aorta-bilateral femoral graft and three vessel heart graft with pump. Most of these patients have not encountered any problems resulting from the procedure. A few patients have had physical problems, e.g. poor veins, poor circulation, lowered blood pressure or excessive apprehension about the procedures. In these cases, the procedures were modified and in one instance discontinued.

Conclusion

We have found that the autotransfusion program is workable, is relatively simple and that the program is utilized by hospital surgeons at all the community hospitals in our area. In our experience, we have found that the patient cooperates readily and usually welcomes the idea of autotransfusion. Most important of all, it makes transfusion therapy safer for patients.

Author **Margaret Halward** *(R.N., St. Joseph's Hospital School of Nursing, Hamilton, Ont.) has been the Head Nurse of the I.V. and Blood Collection Team at St. Joseph's Hospital in Hamilton since 1974 and is a member of the Canadian Intravenous Nurses Association and the American Association of I.V. Therapists, Inc.*

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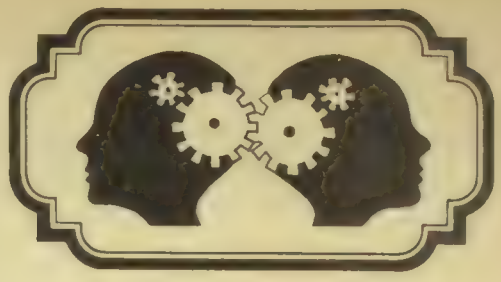
Clinical Wordsearch no.5

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has five words. (Answers page 47)."

G K T C P F O L I C G N I D E E L B
N H A H U B G H N I L E U K E M I A
O P M C R W S T E L E T A L P R H A
I M O M P O B G G D O N O R O S P I
T Y L S U R M A Y O B A T T I A O M
A L E N R R O B X L U T C S C S R E
L M Y O A A I R O N F A O K P N T N
O A M I I M O O M C F T E T L E U A
S C E S E E D C D H Y D L O A G E C
I R L U S N V E R C C T I L S I N I
E O P F I O R T O E O E O C N T T T
S C I S U B T K L L A S D P A N C S
R Y T N R P U L O I T I B C E A H A
E T L A B E S S E I D O B I T N A L
V I U R L A I T N E R E F F I D I P
E C M T S I C K L E C E L L V V I A
R F I B R I N E G A H R R O M E A H

1 A crescent-shaped red blood corpuscle *(6,4)*
2 Thrombus *(4)*
3 A protein essential for coagulation, formed from fibrinogen *(6)*
4 Blood replacement *(11)*
5 A loss of blood which, if severe, produces shock *(11)*
6 Pertaining to the largest of R.B.C's. *(10)*
7 An acid, member of B vitamins which, if deficient, produces anemia. *(5)*
8 Contusion *(6)*
9 Color of erythrocytes *(3)*
10 Plymh *(anagram)*
11 Important source of whole blood *(5)*
12 Disseminated intravascular coagulation *(3)*
13 A laboratory test showing the number of various leukocytes, usually expressed as a percentage of total white count. *(12)*
14 An anemia caused by a disease of the bone marrow. *(8, 6)*
15 A malignant disease affecting the bone marrow, spleen and lymph nodes, characterized by a decrease in R.B.C.'s and platelets, a tendency to bleed and increased susceptibility to infection. *(8)*
16 Condition characterized by an over-abundance of W.B.C.'s *(12)*
17 Thrombocytes *(9)*
18 Plasma-free centrifuged blood. *(6, 5)*
19 Thin layer of leukocytes adhering to R.B.C.'s in centrifuged blood. *(5, 4)*
20 Caused a staining problem for Lady Macbeth *(5)*
21 Protective measure for patients with severe neutropenia. *(7, 9)*
22 Decreased number of platelets *(16)*
23 Extravasation of blood in 22. *(7)*
24 Spalam *(anagram)*
25 Mineral necessary for the production of haemoglobin *(4)*
26 You'll be blue in the face without it. *(6)*
27 A neutral-staining granulocyte. *(10)*
28 A real shame in Britain. *(8)*
29 Foreign proteins which stimulate a protective response in the body. *(8)*
30 One of many types of agglutinogens found in the erythrocytes of 85% of Caucasians. *(2,6)*
31 They form in response to 29. *(10)*
32 Site of haematopoiesis. *(4, 6)*
33 A malignant disease of 32. *(8, 7)*
34 Total iron binding capacity *(4)*
35 System of blood typing used as the basis for whole blood transfusions *(3)*
36 Measurement of the average haemoglobin concentration /100 ml. of packed red cells. *(4)*
37 Haemoglobin *(3)*
38 Haematocrit *(3)*
39 Partial thromboplastin time *(3)*
40 Kilogram *(2)*
41 Measurement of the average volume of individual red cells *(3)*



connection

Rebecca Inns

We all know the sensation of being caught up in a microcosmic slice of life that is made unforgettable by the intensity of our subjective awareness of what is happening around us. Afterwards, we can recall these situations with unusual clarity, almost at will, and thus they serve as excellent learning resources.

For me, as with many other nurses, one of these occasions involved the sudden death of one of my patients ... It was during my fourth year as a nursing student on my first day assigned to a neurology ward.

I listened to morning report and proceeded down the hall to greet my patient, Mr. L. On arrival, I was puzzled for a moment by the number of people in the room until I realized that the cardiac arrest code I had heard was for *my* patient.

Panic struck at me! What was I supposed to do now? I wandered around in confusion trying to stay out of everyone's way.

About this time, someone phoned Mr. L.'s family and told them that he had taken an unexpected turn for the worse.

After what seemed a long time, Mr. L. was pronounced dead and the horde of people dispersed to continue with their individual tasks. I stood there and looked at my patient. This was my first close contact with death. In the past, when I had thought about how I would feel in this situation, I had expected to be sad and, probably, frightened but I wasn't. I felt like an empty shell, an unconcerned onlooker. I packed his belongings as I was asked to, and marvelled at my detachment as I waited for the family to arrive. Perhaps, I thought, I have become cold and methodical in my nursing even before my graduation day.

Mrs. L., her daughter and son-in-law arrived and were directed into a quiet room after they had been informed of Mr. L.'s death. I thought I would leave; I rationalized that they would rather be alone. I had read that people like supportive company in times of stress but I wanted to believe otherwise. Perhaps I was afraid of that unknown enemy "death." I feared to share in the expression of those raw emotions brought about by grief. My instructor caught up with me as I was half running up the corridor. She "suggested" I go in and sit with the L.'s in their grief.

I entered the room with cups of coffee for Mrs. L. and her daughter. The son-in-law had returned to his office for an hour leaving definite instructions that the other two were not to see Mr. L.'s body until he returned. I sat down with the two women wondering what to do or say next. I knew little about death, next to nothing about the patient and not a thing about the family.

The first couple of minutes were uneasy as I tried to establish some rapport. I was nervous because I wanted to help them but I didn't know how to go about it, where to begin. As we became a little more familiar with each other I began to relax and not worry about every word. After a while, even the silences became more comfortable and I found I was forgetting about myself in the situation and empathizing with the L.'s, wondering how I would feel in their situation.

Mrs. L.'s behavior changed from a period of depressed withdrawal during which she cried and stared out the window, to edging around on her chair and listening to her daughter and me. Finally, she began to participate in the interaction, giving a complete description of Mr. L.'s illness and revealing much anger in doing so.

At the time I remember thinking how controlled the daughter was. Afterwards, however, I wondered whether perhaps she was a little too assured, too gay, and that this was her way of coping with her father's death and her mother's obvious grief.

I feel that this incident raises a number of points pertinent to nursing today.

Nursing education emphasizes a "holistic" approach to patient care. Thus, if a patient dies suddenly, helping the famly cope with their grief is an extension of caring for the patient. One might ask if this duty should be included in the already busy schedule of the hospital nurse but I think that it is the nurses who have come to know the patient and his family who are best equipped to help the survivors deal with their immediate reaction to their loss.

Another query that comes to mind is whether such a short involvement after death is beneficial. There *are* programs in operation that include ongoing services to bereaved families but unfortunately these are not always available.

All in all, even a short-term involvement on the nurse's part can be helpful to the family who infer from this that she considers them and their loss important enough to sit down and grieve with them. By taking time to be with the family she is also showing them she cares about them and what they will do now. She can also help them begin to acknowledge and accept their loss.

Dr. Elisabeth Kubler-Ross identifies five stages of reaction to grief:

- shock and denial
- anger
- bargaining
- depression
- acceptance.

It is unrealistic to hope that the family will

time immediately following the death of their loved one. But if they spend some time with a nurse who gives them the impression that she cares about someone they were so close to, and who accepts his death, they can begin to progress through these stages.

My third concern is the conflict that I felt existed between the hospital's needs and those of the patient and his family. During the time I spent with Mr. L.'s family, two interruptions occurred. The first involved a staff nurse who came in to ask the family whether they would consider changing their minds about refusing to have an autopsy done. The second was the same nurse who returned to request that the family see "the body" right away.

In the first instance, a staff nurse entered and stated that the doctor would like very much to do a post mortem on the patient. She asked whether the family would consider changing their decision. The wife looked lost. The daughter looked first to her mother and then to me for guidance.

ME: "You don't want an autopsy?" in a surprised tone as I did not know the topic had already been discussed.

DAUGHTER: "Well... we thought ... why bother? He's gone." She sounded surprised that anyone would consider having an autopsy.

STAFF NURSE: "Well. It would aid medical research and help us a great deal." She remained standing in the doorway and looked impatient.

There was an uncomfortable silence. I did not know whether to speak or not. I empathized with both the doctors and the family. On one hand, I agreed with the family that it seems an unnecessary violation to subject their loved one's remains to a pathologist's knife. On the other hand, I knew that Mr. L.'s cause of death was unknown and that, in the past, autopsies have resulted in major contributions being made to medicine, including the discovery that appendicitis may cause death and that a simple appendectomy could rectify the situation.

I pondered over whether I had any right to try to influence the family's decision. At the same time, I was conscious of being acutely uncomfortable because of my ambivalent view of the situation, and the feeling that I wanted to do what was best for the family but also to please the hospital.

In the second instance, the same nurse entered the room to ask if the family would like to see "the body." A look of shock and pain passed over the wife's face. (I had never thought about the use of the word "body" before but remembering that look will certainly make me reconsider before using it in the future!) The daughter looked around for support and said she was not sure if she wished to see her father.

ME: "Do you think it could wait until the son-in-law returns? He should be back in about five minutes."

STAFF NURSE: "It's just that the other patient wants back in his room." There was an uncomfortable pause.

I vascillated between complying with the nurse's request and thus enabling the hospital's routine to run more smoothly, leaving the decision with the family or defending them against the bureaucracy.

ME: "Well, the son-in-law said he'd be back in half an hour, twenty-five minutes ago."

STAFF NURSE: "Okay."

In each of these situations, there was an element of conflict that is present throughout nursing practice and which, I feel, every nurse needs to resolve. My feelings of ambivalence during the two encounters made it clear to me that throughout my nursing career I must continually re-examine my professional standards, and help to ensure that the hospital's and the nurse's goals are the same — i.e. to provide care for the patient and his family.

Spending even that brief time after the death of a patient with those who were close to him shows that you *do* care and leaves the family feeling not quite so alone.

Nursing is a caring profession and the nurse must help those who need her assistance in whatever capacity she can.



A June 1976 graduate of the University of Ottawa's baccalaureate course in nursing science, **Rebecca Inns** *says she "loves living in California", where she works as a staff nurse on the Orthopedic Surgery ward at Marina Mercy Hospital in Marina del Rey. She plans to transfer soon to Harbor General Hospital in Los Angeles to work on a general surgery ward.*

Before moving to California, Rebecca worked as a Camp Nurse near Huntsville, Ontario. She has also done volunteer work at Red Cross Blood Donor Clinics.

She enjoys California but plans to return to Canada someday. This is her first published story.

Ready for any emergency 200-bed hospital-in-a-box

Sandra LeFort

If a major emergency situation involving a large number of casualties occurred in your community, what would you do? Do you know enough first aid right now to be able to treat victims until further help is available? Does your local hospital have a disaster plan?

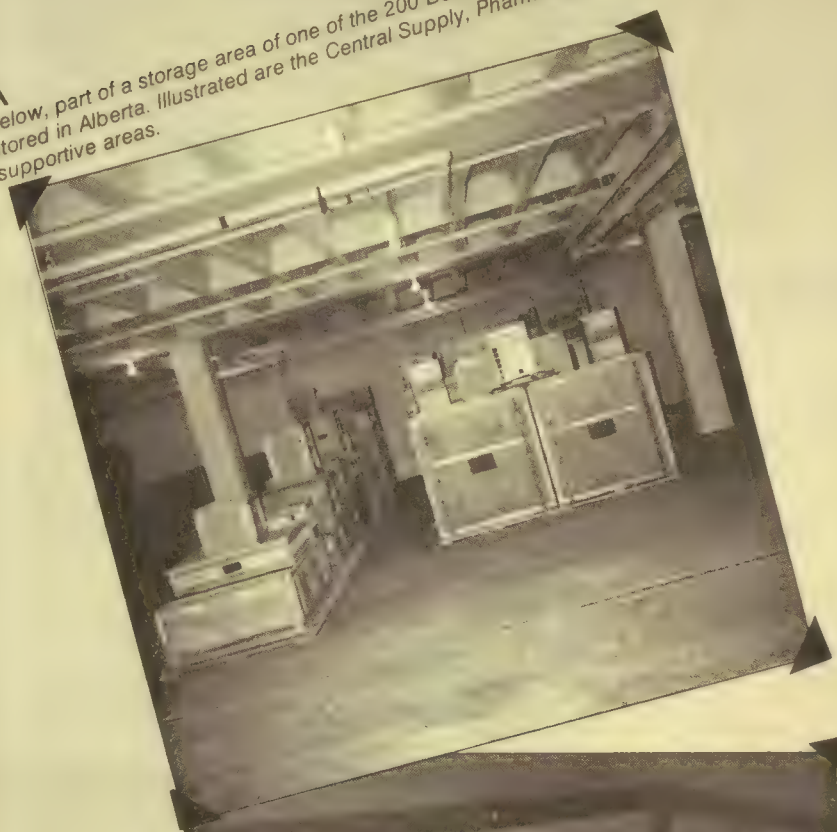
The idea of a disaster or large-scale emergency is far from the minds of most of us living out our day-to-day lives in Canada. If we think about it at all, we agree that disasters do happen — but they happen in Latin America, or China, or the South Pacific. We seldom think in terms of earthquakes or major floods in relation to ourselves. It seems to be part of the "it can't happen to me: it only happens to the other guy" syndrome.

Large-scale disasters know no geographic bounds. They can and do happen anywhere, and when they occur it is to the health professions that survivors look for help.

Within the last 25 years, Canadians have witnessed several major disasters, including the one in the coal mines in Springhill, Nova Scotia in 1958, the collapse of the Second Narrows Bridge linking Vancouver to North Vancouver that same year, and Hurricane Hazel in southern Ontario in 1954. In recent years, television has immeasurably increased the immediacy of such events and the memory of them is vivid in the minds of many people.

The more advanced and complex technology taking over every facet of living has increased by leaps and bounds the possibilities for unforeseen disasters that involve dozens or even hundreds of people. Jumbo jets, trains, buses and the ubiquitous automobile, huge construction projects, tankers transporting hazardous products all have the potential for creating extreme emergency situations. All carry with them the threat of large numbers of casualties occurring simultaneously within one community. What happens when the strain that an event of this scale places on a community's hospital emergency services is too great?

A Below, part of a storage area of one of the 200 Bed Emergency Hospitals stored in Alberta. Illustrated are the Central Supply, Pharmacy, and other supportive areas.





B *The 15 MA x-ray machine prepared for vertical fluoroscopy.*

C *This star-shaped formation is utilized in the 10-bed Post-Operative Recovery Area. As the Emergency Hospital will function in a high school, the other 5 beds, not shown in this photo, would be set up along the wall perimeter.*





D *This photo shows the star-shaped formation of the stretchers around the oxygen supply with the five-way adapter and the Wagensteen gastric suction apparatus in the area of Pre-Operative Resuscitation. This stretcher arrangement provides a small intensive care unit.*

Disaster planning

Lorraine Davies, Director of Emergency Health Services, Health and Welfare Canada since February 1976, was formerly the nursing consultant for the province of Nova Scotia's Emergency Health Service. She sees the need for a more organized and coordinated way of dealing with the type of emergency situation that may result in an unusually large number of dead and injured people and believes that it is necessary for hospitals and health professionals to be prepared to deal with an extreme emergency situation.

Emergency Health Services in Ottawa, a Division of the Medical Services Branch of Health and Welfare Canada, provides expertise and assistance to provinces in the area of emergency health planning as well as allocating equipment to be used for specified disasters. This equipment is then pre-positioned throughout the provinces. It includes: casualty collecting units; advanced treatment centers; blood donor packs; hospital disaster supplies such as additional stretchers, dressings, intravenous solutions etc. Hospital disaster supplies are forwarded by the province to hospitals with approved disaster plans. Some of this equipment has been utilized, at various times, by different hospitals in emergency situations when they required augmentation of their normal emergency supplies.

Hospital-in-a-box

On a larger scale, but part of the same Health and Welfare Package, is the "Two Hundred Bed Hospital" — a completely functional hospital that can be utilized anywhere that the need occurs in Canada. Emergency Hospitals are to be used only in the event of a disaster of major magnitude necessitating the reinforcement or replacement of local hospital facilities. On May 22, 1966, the Stanton Yellowknife Hospital burned to the ground and a portion of the Emergency Hospital including X-ray, Laboratory, Pharmacy, Operating Room, Central Supply and Ward supplies and equipment was used in the town of Yellowknife for nearly seven months. Emergency Health Services, Alberta, as directed by the Government of Canada, flew the equipment by R.C.A.F. Hercules to the town. With the supervision of a member of Alberta Emergency Health Services, the equipment was assembled in the Elk Hall and within four hours of its arrival, the hospital was operational. The staff found the equipment to be of high quality, fulfilling all the requirements necessary for a hospital. This was the first time that an Emergency Hospital

had been functionally utilized in Canada. The hospital equipment is packed in 594 boxes designed for long-term storage. The total weight of the hospital is 42,000 lbs. and requires two 40' vans, one freight car, or one Hercules plane to transport it. It is self-sustaining for seven days. In time of disaster in Canada the Emergency Hospital would probably be assembled and function in a school or other selected shelter. Classrooms, for instance, would provide space for the operation of the functional areas. It takes approximately one hundred and twenty man hours for the hospital to be made operational — i.e. 30 skilled people working for four hours to assemble it. A staff of 263 people are required to provide the services within the Emergency Hospital.

Everything you really need

This hospital is complete in every respect:

- There are ten wards made up of eight general wards and two special wards that serve as pre- and post-operative areas. The beds in the wards are constructed of a lightweight tubular metal, with a nylon-cotton waterproof deck which is held in place by a non-stretchable nylon cord.
- The three Operating Rooms each contain a lightweight folding table, surgical lamp, anesthetic apparatus, utility tables, Mayo stands, electrical suction machine and oxygen cylinders.
- The Central Supply Room, also well equipped, contains two portable autoclaves and a water boiling sterilizer. The autoclaves can function from a variety of heating sources; propane gas, natural or mixed gases, steam or electricity. Is is here that the surgical trays and equipment are sterilized. Also, some Ward supplies are obtained from this area, along with surgical instruments.
- A large Pharmacy and Pharmacy stores, provide the medication, dressings, intravenous solutions, anesthetic supplies and the special equipment and supplies necessary for the efficient operation of an Emergency Hospital.
- The Hospital has its own Laboratory with the basic equipment to perform 500 basic laboratory tests. A blood donor kit is sometimes stored with the Emergency Hospital with supplies to obtain 100 pints of whole blood.
- The x-ray area contains an x-ray machine, portable film processing machine and other equipment necessary for the provision of a sound x-ray service. Polaroid film is used to take the x-rays and only ten seconds is required to process the film.



Photos courtesy of Alberta Emergency Health Services

An overall view of an area of the 200 Bed Emergency Hospital, showing part of a 20 bed general ward, post-operative recovery, operating room, pre-operative resuscitation, and admitting areas.

A three-kilowatt portable, gasoline-powered generator is supplied as an auxiliary power source for the x-ray unit. Besides the basic areas, there is a Utilities Area which contains a fifteen hundred gallon water storage tank. An electrical pump gives pressure from the tank to three taps within the hospital. Auxiliary electrical power is obtained by means of a ten kilowatt gasoline powered generator. Twenty of these hospitals were provided to the Government of South Vietnam to assist in the provision of medical and surgical care for the civilian population. A team of experts from the Federal Emergency Health Service trained the Vietnamese personnel in the use of the equipment. The Canadian government also provided four Emergency Hospitals to Nigeria after the war in Biafra.

Thanks go to **Carolynne E. Ross,** *Nurse Consultant for the Alberta Emergency Health Services and to* **Lorraine Davies,** *Director of Emergency Health Services, Health and Welfare Canada for their help in the preparation of this article.*

Clinical Wordsearch

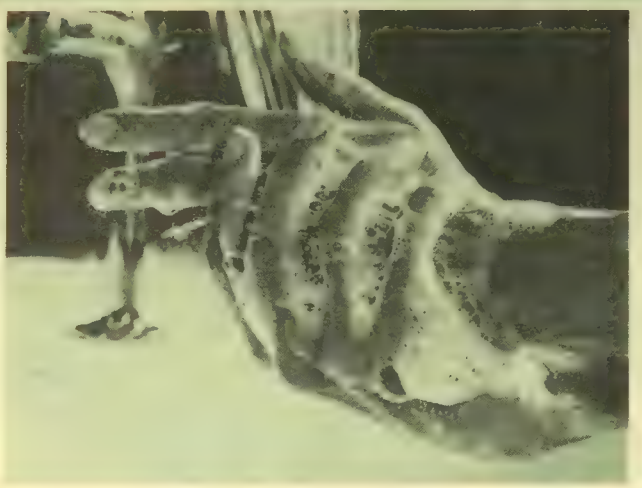
Answers

Puzzle no. 5 *(appears on page 42).*

1 Sickle Cell
2 Clot
3 Fibrin
4 Transfusion
5 Haemorrhage
6 Macrocytic
7 Folic
8 Bruise
9 Red
10 Lymph
11 Donor
12 DIC
13 Differential
14 Aplastic Anemia
15 Leukemia
16 Leukocytosis
17 Platelets
18 Packed Cells
19 Buffy Coat
20 Blood
21 Reverse Isolation
22 Thrombocytopenia
23 Purpura
24 Plasma
25 Iron
26 Oxygen
27 Neutrophil
28 Bleeding
29 Antigens
30 Rh Factor
31 Antibodies
32 Bone Marrow
33 Multiple Myeloma
34 T.I.B.C.
35 A.B.O.
36 M.C.H.C.
37 Hgb
38 Hct
39 P.T.T.
40 Kg
41 M.C.V.

Hidden Answer: Give blood, it's so vital

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Calendar

May

Life, Death and Freedom, a residential workshop held May 27-29, 1977 in Devon, Alberta. Open to members of the helping professions who are involved with any reaction to loss. Contact: *Grant MacEwan Community College Continuing Education Division, 10045-156 Street, Edmonton, Alberta.*

June

Canadian Council of Cardiovascular Nurses Nova Scotia Branch: Annual Two-Day Workshop to be held June 2-3, 1977 at the Tupper Bldg., Halifax. Contact: *Donna Rhodes, 706 — 5681 Rhuland St., Halifax, N.S. B3H 4J6.*

8th Annual Meeting of the Canadian Association of Neurological and Neurosurgical Nurses to be held at the Loews Concorde Hotel in Quebec City on June 15-17, 1977. Contact: *Ms. Beth Cook, 59 Warren Road, Toronto, Ontario. M4V 2R9.*

68th Annual Conference of the Canadian Public Health Association to be held in Vancouver, B.C. on June 28-30, 1977. Contact: *CPHA, 1335 Carling Ave., Suite 306, Ottawa, Ontario, K1Z 8N8.*

Canadian Paediatric Society 54th Annual Meeting to be held at the Bonaventure Hotel in Montreal on June 25-29, 1977. Contact: *Dr. Victor Marchessault, Executive Secretary, Canadian Paediatric Society, Centre Hospitalier, Université de Sherbrooke, Sherbrooke, P.Q. J1H 5N4.*

International Conference on Medical Device Regulation sponsored by Health Protection Branch, Health and Welfare Canada and the Association for the Advancement of Medical Instrumentation. To be held June 14-16, 1977 in Ottawa. Contact: *Director, Bureau of Medical Devices, Health Protection Branch, Health and Welfare Canada, Ottawa, Canada.*

Canadian Guidance and Counselling Association National Conference to be held in Montreal on June 14-18, 1977. Theme: "Toward the development of human resources" with keynote speakers, Hans Selye, Viktor Frankl and Marie-Andrée Bertrand. Contact: *Secretariat, 1895 avenue de La Salle, Montreal, Québec, HIV 2K4.*

Developing Learning Modules for Nursing Instruction. To be held at the Holiday Inn, Calgary, Alta., on June 28-30, 1977. Contact: *Institute of Nursing Consultants, Fay Bower, 1820 Portola Road, Woodside, California, 94062.*

First Congress of Nurse Healers to be held in San Francisco, California on June 10-12, 1977. Theme: The nurse healer of tomorrow: a futuristic view. For information contact: *East West Academy of Healing Arts Council of Nurse-Healers, Congress, 33 Ora Way, San Francisco, Calif. 94131.*

July

Class of '67 Ten Year Reunion of Registered Nurses of the St. Boniface General Hospital, Winnipeg, Manitoba. To be held July 9-10, 1977. For information contact: *Doreen Pattie, 34 Inwood Crescent, Winnipeg, Manitoba, R2Y 1A3.*

Futuration ' 77. The 12th Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, Winnipeg, Manitoba on July 10-15, 1977. Information: *Conference Manager, Futuraction '77. The Alcoholism Foundation of Manitoba, 1580 Dublin Ave., Winnipeg, Man., R3E 0L4.*

August

Health Care Evaluation Seminar. A one-week seminar for those interested in health care evaluation to be held at Memorial University of Newfoundland, from August 29-Sept. 2, 1977. Applications due June 1. Contact: *Patricia Bruce-Lockhart, Division of Community Medicine, Faculty of Medicine, Memorial University of Newfoundland, St. John's, Newfoundland, A1B 3V6.*

Strategies for Curriculum Change. To be held in Winnipeg, Man. on August 18-20, 1977. Contact: *Institute of Nursing Consultants, Fay Bower, 1820 Portola Road, Woodside, California, 94062.*

Canadian Society of Respiratory Technologists Annual Education Forum to be held at the Holiday Inn, Winnipeg, Manitoba on August 30 - Sept. 2, 1977. Contact: *Kathy Irving, Registration Chairman, P.O. Box 1841, Winnipeg, Manitoba, R3C 3R1.*

Fourth Annual Meeting/ Educational Workshop of the American Association of Diabetes Educators. To be held in Denver, Colorado on Aug. 14-15, 1977. Contact: *American Association of Diabetic Educators, 3553 W. Peterson Ave., Chicago, IL 60659.*

World Federation for Mental Health - 1977 Congress, "Today's Priorities in Mental Health," to be held in Vancouver, B.C. from August 21 - 26, 1977. The focus of the meeting will be on finding ways to make health systems work for all the people, including the mentally ill. Techniques of Health By The People will be emphasized. For further information contact: *Secretariat, World Federation for Mental Health, Health Sciences Centre Hospital, 2075 Wesbrook Place, The University of British Columbia, Vancouver, B.C. V6T 1W5.*

Symposium on Canada and World Food to be held at Carleton University, Ottawa on August 22-24, 1977. Multidisciplinary topics discussed. Contact: *The Royal Society of Canada, 344 Wellington St., Ottawa, Ont., KIA 0N4.*

September

Emergency Nurses Association of Ontario Annual Conference to be held September 12-14, 1977 at the Skyline Hotel, Ottawa, Ontario. Contact: *Helen McPhee, Supervisor, Emergency Department., Ottawa Civic Hospital, 1053 Carling Ave., Ottawa, Ontario.*

70th Anniversary Reunion of the Holy Cross Hospital Nurses Alumnae to be held on Sept. 17 to 18 1977 in Calgary, Alberta. For furthe information, contact: *Mrs. Ella Benner, 2007 — 23rd Ave. N.W., Calgary, T2M 1W2.*

Spinal Cord Injury Workshop — Multidisciplinary Approach. To be held on Sept. 19-21, 1977 at the Siste Kenny Institute in Minneapolis, Mini Contact: *Dianne Talbot, R.N., Nursing Education, Sister Kenny Institute, 81 East 27th Street, Minneapolis, Minnesota, 55407.*

American Cancer Society Second National Conference on Human Values and Cancer to be held September 7-9, 1977 in Chicago, Illinois. For information contact: *American Cancer Society, Second National Conference on Human Values and Cancer, 777 Third Avenue, New York, N.Y. 10017.*

October

Sixth Annual General and Scientifi Meeting of The Canadian Association on Gerontology to be held October 13-16, 1977 in Montrea at Loews "La Cite" Hotel. Contact: *Blossom T. Wigdor, Ph.D., Director, Psychology Services, Queen Mary Veterans Hospital, 4565 Queen Mar Road, Montreal, Quebec, H3W 1W5.*

Colloquium on Bio-Medical Ethics to be held Oct. 27-30, 1977. Sponsored by the Faculty of Medicin and the Department of Philosophy o The University of Western Ontario. Papers on various topics are invited For further information write to: *Professor John Davis, Department o Philosophy, The University of Weste Ontario, London, Ontario, N6A 3K7.*

12th Operating Room Nurses Conference to be held by the O.R. Nurses of Nova Scotia on Oct. 18-20 1977 in Halifax. Contact: *Miss L. Hirtle, R.N., Halifax Infirmary (OR), 1335 Queen St., Halifax, Nova Scotia*

Names and Faces



M. Josephine Flaherty has resigned her position as dean, Faculty of Nursing, University of Western Ontario, to accept the appointment of **Principal Nursing Officer,** Department of National Health and Welfare. A native of Toronto, she received her B.Sc.N., B.A., and M.A. degrees from the University of Toronto and was awarded a Ph.D for her work in statistics and measurement in education. Extensively involved in adult education, she has conducted studies into the need for continuing education for registered nurses in Ontario and into the academic potential of mature students. Her nursing background includes general duty nursing, public health nursing and teaching in university and diploma nursing programs. She is a past president of the Registered Nurses Association of Ontario, and a former director of the Canadian Nurses Association and the Canadian Nurses Foundation. She was associate professor at the Ontario Institute for Studies in Education and the University of Toronto before her appointment as dean, Faculty of Nursing, University of Western Ontario in 1973. She will assume her new duties as Principal Nursing Officer this summer.

Roselyn Smith (R.N., St. Paul's Hospital School of Nursing, Vancouver; B.N., McGill University) has been appointed director of nursing, Children's Hospital, Vancouver, B.C. Previously, she was director of nursing at Montreal Children's Hospital in Montreal, Quebec.

Adele Herwitz, past executive director of the International Council of Nurses and a former associate executive director of the American Nurses' Association has been appointed executive director of the Commission on Graduates of Foreign Nursing Schools. The organization, formed nine months ago, will establish a screening program for foreign nurse graduates seeking to enter the United States. Herwitz assumed her new duties on April 1.

Phyllis Burgess (R.N., Toronto General Hospital School of Nursing) recently retired from her position as director of nursing at the Ontario Cancer Institute, Princess Margaret Hospital, Toronto. After working with cancer patients for 37 years she was honored by the City of Toronto and was the recipient of an Award of Merit. She plans to have a productive retirement and to continue as a volunteer in Coping with Cancer groups where patients are encouraged to discuss their feelings about cancer.



J. Patricia Holder has been appointed Director of Nursing at The Princess Margaret Hospital following the retirement of Phyllis Burgess. Holder was previously with the North York General Hospital in Toronto.

Corine Marlatt (R.N., Edith Cavell Regional School of Nursing, Belleville, Ont.) recently arrived in Afghanistan to serve a two-year tour of duty with MEDICO, a service of CARE. She is stationed at a new 250-bed hospital in the Afghan capital of Kabul where she will be working in supervisory and teaching capacities in the surgical wards, intensive care units and recovery room. Her main duty will be to upgrade the training of local nurses and students.

Prior to joining CARE/MEDICO, Marlatt was a staff nurse at the University of Alberta Hospital in Edmonton and at the Belleville General Hospital, Belleville,Ont.

The Health Sciences Department of Grant MacEwan Community College has announced the appointments of:



B. June Colberg, (R.N., B.Sc., M. Ed.) as Instructor of the Extended Care Nursing Certificate Program. She has past experience in nursing service and in education, her most recent post being Chairman, Department of Nursing, Cariboo College, Kamloops, B.C.



Elizabeth Dawson (R.N., B.Ed.) as Instructor of the Occupational Health Nursing Certificate Program. She has had previous experience in occupational health, teaching and social work.



The Canadian University Nursing Student Association (CUNSA) is sending two representatives— **Peggy Wareham** (above), national chairperson of CUNSA, Memorial University, St. John's, Newfoundland and **Mary Comer** national research coordinator, Mount St. Vincent University, Halifax, N.S — to the 1977 ICN Congress in Tokyo later this month. A student assembly held at the Congress on May 30 will give student representatives from across the world the opportunity to discuss topics of interest to all nursing students.

Virginia A. Lindabury, former editor of *The Canadian Nurse,* is now managing editor of two magazines in Naples, Florida — the *Naples Guide,* a 112-page magazine published monthly for tourists, and *Naples Now,* a new publication for southwestern Floridians.

Lindabury, a graduate of Toronto General Hospital School of Nursing and the University of Western Ontario, left *The Canadian Nurse* in 1975, after 13 years with the magazine. She vacationed in Florida — where most of her family live — for a year, then accepted the position last July as advertising sales representative with Reynolds Enterprises. She was in that job six months before being appointed managing editor.

Glennyce Sinclair, (R.N., B.Sc.N.) has been appointed Director of the Diploma Nursing Program at The College of New Caledonia, Prince George, B.C. This is a new College program and will commence in September.

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New 3rd Edition! **THE PROCESS OF PATIENT TEACHING IN NURSING.** *By Barbara Klug Redman, R.N., B.S.N., M.Ed., Ph.D.* This expanded new edition offers important principles and methods for patient teaching. Discussions present timely information on behavioral objectives, care plans, legal aspects, and other topics! June, 1976. 282 pp., 14 figs. **Price, $8.15.**

A New Book! **HEALTH ASSESSMENT.** *By Lois Malasanos, R.N., Ph.D., Violet Barkauskas, R.N., C.N.M., M.P.H.; Muriel Moss, R.N., M.A.; and Kathryn Stoltenberg Allen, R.N., M.S.N.* Written *by* nurses *for* nurses, this comprehensive text describes and illustrates the techniques and procedures necessary to obtain a complete health history and perform a thorough physical examination. July, 1977. Approx. 576 pp., 683 illus., 239 in 2-color. **About $22.00.**

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A New Book! **LIFTING, MOVING, AND TRANSFERRING PATIENTS: A Manual.** *By Marilyn J. Rantz, R.N., B.S.N. and Donald Courtial, R.P.T., B.S.* This valuable new book describes and illustrates the safest and easiest methods for handling and transferring patients with special problems or injuries. January, 1977. 148 pp., 250 illus. **Price, $7.30.**

A New Book! **INTRODUCTION TO NURSING ESSENTIALS: A Handbook.** *By Helen Readey, R.N., M.S.; Mary Teague, R.N., M.S.N.; and William Readey III, B.S.* This concise handbook synthesizes basic information essential to all beginning nursing students. Topics range from communication and terminology to P.O.M.R., mathematics, nursing process, and legal aspects. April, 1977. Approx. 176 pp., 19 illus. **About $5.80.**

3rd Edition! **THE FOUNDATIONS OF NURSING: As Conceived, Learned, and Practiced in Professional Nursing.** *By Lillian DeYoung, R.N., B.S.N.E., M.S., Ph.D.; with 4 contributors.* Examine the many dimensions of modern professional nursing — opportunities, responsibilities, and personal and social roles with this informative text. 1976, 316 pp., 43 illus. **Price, $9.40.**

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New 4th Edition! MICROBIOLOGY LABORATORY MANUAL AND WORKBOOK. By Alice Lorraine Smith, A.B., M.D., F.C.A.P., F.A.C.P. April, 1977. Approx. 192 pp., 46 illus. About $7.30.

New 2nd Edition! BIOCHEMISTRY: A Case-Oriented Approach. By Rex Montgomery, D.Sc.; Robert Dryer, Ph.D.; Thomas E. Conway, Ph.D.; and Arthur A. Spector, M.D. April, 1977. Approx. 720 pp., 266 illus. About $12.10.

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A New Book! NURSING CARE EVALUATION: Concurrent and Retrospective Review Criteria. *By Sharon Van Sell Davidson, R.N., B.S.N., M.Ed.; with 3 coordinating authors.* The authors provide guidelines and model criteria for *both* concurrent and retrospective nursing audit of more than 250 disease and medical conditions. They present systems compatible with Professional Standards Review Organizations. August, 1977. Approx. 600 pp. **About $15.70.**

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Books

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Health Care Dimensions: Health Care Issues, edited by Madeleine Leininger and Gary Buck. 163 pages, Philadelphia, F.A. Davis Company, 1974. Canadian Agent: Toronto, McGraw-Hill, Ryerson.
Reviewed by Jean E. Innes, Associate Professor, College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

"Health care providers and consumers are concerned about improving health care services, but many are not clear about the issues, goals, barriers, and facilitators involved in the provision of care. Before one can change any health care system the changers must first understand some of the major issues, historical facts, and the forces influencing our health care system."

The purpose of this publication is to share such knowledge and different viewpoints with an attitude of "let's share and discuss together" in an interdisciplinary climate and with an interdisciplinary perspective. Eleven papers are presented for study, most of which are relevant to the delivery of health care in Canada. Issues dealing with emerging priorities, equity of access, and technology as a means of improving health conditions and increasing options should interest professionals concerned with improved delivery of service.

The book begins on a philosophical base and moves quickly into discussions on crises in health care, humanistic issues in health care, humanism, health, and cultural values and their influence on care. These papers identify major issues currently causing concern in Canada, e.g., evaluative research in health, a conceptual analysis, social organization of health and the myth of free choice, and an analysis of the health and illness care system.

The papers presented on the political context and health legislation, emerging health services projects, and abortion in the United States have some interesting points to make, but generally may not interest the Canadian reader and, in some instances (as the paper on abortion), seem out of place. University researchers and teachers will find the paper on universities and future health care challenging and debatable in a political context, but the major point of the paper deals with the fact that the potential of universities to contribute to improved health care has not been fully realized. Factors contributing to this state are discussed.

In general, this seems to be a very worthwhile text. The papers are well written and well presented, and the purpose of the publication is realized. True to the cause, the papers do not single out one group of professionals to harass or challenge, but present an overview of the issues influencing the total health system. Major concepts are presented and a good deal of knowledge can be shared with the reader.

The text would be valuable to teachers of health care classes at the university level, as well as for students in their senior year. Health professionals generally would benefit from reading and discussing many of the papers presented in this text.

Nursing Service Administration: Managing the Enterprise by Helen M. Donovan, The C.V. Mosby Company, St. Louis, 1975. 265 pages.
Approximate price $7.10. Reviewed by Doreen Little, Director of Medical Nursing, University Hospital, Saskatoon, Saskatchewan.

The author has directed this book to all nurses who are responsible for the work of others. Her premise is that all nurses are responsible for achieving the goals of nursing service and as such, all are administrators to some degree.

Although this book is directed primarily to the nurse in an institutional setting, application is possible in other settings.

This book is divided into three parts. Part I is titled, "Administration in Nursing." It deals with a definition of administration, patient's rights, nurses' rights, and the relationship between administration and nursing care.

Part II is titled, "Framework for Study of Nursing Service Administration." The component parts of administration are dealt with in this section. There are chapters on planning, organizing, staffing, directing, controlling, coordinating, reporting and budgeting.

Part III looks at, "Adjuncts to Nursing Service." In this section, the author looks at inservice education, personnel policies and contracts, equipment, research and public relations.

The author meets her objective in reviewing the administrative process broadly. Such a broad overview by nature overlooks specific details. For example, the chapter on staffing discusses different patient classification systems. The reader may use the information presented as a base to look further but there is not sufficient information to choose a suitable system.

At the end of each chapter there is a thorough reference list for the readers' use.

Although this book is addressed to nurses at all levels, I doubt that the general duty nurse would select this type of text as her choice of reading. It would seem to me that this text could be used by a student nurse studying the various aspects of nursing administration.

As a nurse involved in administration at a senior level for several years, I found the text lacking in depth. However, the book is designed to provide a fundamental structure to be examined, which it does successfully.

Primary Anatomy (7th edition) by John V. Basmajian. 405 pages. Baltimore: The Williams & Wilkins Co., 1976.
Approximate price $15.45. Reviewed by Charlotte Curtis, Sydney City Hospital School of Nursing, Sydney, N.S.

The aim of this book is to "provide non-medical university students ... with a professional textbook on gross and functional anatomy."

Subject matter is presented in the conventional way by the individual systems approach. For the beginning student, this type of approach is often the easiest.

General organization of material is done very well, especially with the use of headings and sub-headings, making items easy to locate.

One of the outstanding features of the text is the widespread use of illustrations, diagrams and tables. These are of great value to the beginner in understanding basic anatomy. New features of the seventh edition include:
1) a 26-page color atlas with excellent illustrations of such items as muscles, lymphatics, arteries, veins, bones, viscera and nerves;
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Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

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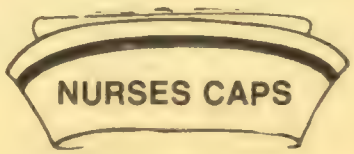
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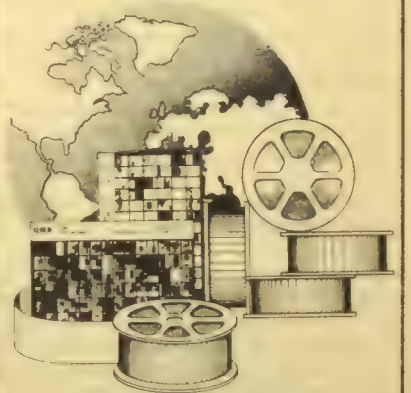
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Personnel Office
IZAAK WALTON KILLAM HOSPITAL FOR CHILDREN
P. O. Box 3070
Halifax, N. S.
B3J 3G9

Associate Executive Director

Applications are invited for the position of Associate Executive director, Canadian Nurses Association, Ottawa.

Candidates must be members of the Canadian Nurses Association, have a master's degree or equivalent and have at least five years' administrative experience. Bilingualism an asset.

Interested applicants are asked to submit their curriculum vitae, in confidence, to:

Executive Director
Canadian Nurses Association
50 The Driveway
Ottawa, Ontario
K2P 1E2

Foothills Hospital, Calgary, Alberta

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For further information, please write to:
Co-ordinator of In-service Education
Foothills Hospital
1403 29 St. N.W. Calgary, Alberta
T2N 2T9

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Head Nurse
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Apply sending complete resume to:

Director of Personnel
Stratford General Hospital
Stratford, Ontario
N5A 2Y6

Sudbury and District Health Unit requires a **Public Health Nurse** for service in Chapleau and surrounding area, preferably bilingual.

Qualifications:
Baccalaureate degree in nursing with Public Health content or equivalent post basic nursing preparation.

Reply to:

Miss F. Tomlinson
Director of Nursing
Sudbury & District Health Unit
1300 Paris Crescent
Sudbury, Ontario
P3E 3A3

Nursing Care Co-ordinator

We require the services of a Nursing Care Co-ordinator for our 100 Bed Auxiliary Hospital. The applicant should have 3 to 5 years experience in nursing with a Bachelor of Science Degree and a background in Administration and Teaching. Must also be interested in Rehabilitation Medicine and Extended Care.

This position is available May or June.

Please apply to:
Director of Personnel
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Red Deer, Alberta
T4N 4E7

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Stratford, Ontario
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Trail, B.C.
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Address correspondence to:

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- Extended Care Nursing Certificate Program
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P.G. Otke, Ph.D.
Director, Mill Woods Campus
Grant MacEwan Community College
7319 - 29 Avenue
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Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

Name

Address

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EMPLOYMENT OFFERS

New positions to be filled in the nursing sector at the Head Office of the Order of Nurses of Quebec.

TITLE: Consultant in nursing care programmes

Principal responsibilities
Under the authority of the director of the nursing sector, this person will act as nurse consultant in matters relating to nursing care programmes and the utilization of nursing manpower; develop new nursing care programmes and methods of utilizing nursing manpower and participate in the activities of the sector.

TITLE: Consultant in nursing care

Principal responsibilities
Under the authority of the director of the nursing sector, this person will act as nurse consultant in matters relating to nursing care and the role of nurses in various work settings; clarify the various functions of nurses; and participate in the activities of the sector.

Qualifications required
- be a member of the Order of Nurses of Quebec
- possess a master's degree in nursing or the equivalent
- have seven years' experience in the field of nursing
- be able to work within a team

Curriculum vitae to be forwarded to:
Executive-Director and secretary of the Order
4200 Dorchester Boulevard West
Montreal, Quebec.
H3Z 1V4

Brandon General Hospital
Department of Nursing Services
Positions Open

CLINICAL TEACHERS:
- Rehabilitation—Extended Care Area
- Maternal—Child Area

To be responsible for the planning and implementation of educational programs within the defined Area.

Qualifications:
- Advanced preparation and/or experience in the Clinical Nursing Specialty with a baccalaureate nursing degree preferred.
- Eligible for registration in Manitoba.

UNIT COORDINATOR:
- Rehabilitation—Extended Care Nursing Unit

To be responsible for the total management of nursing care within this 67 bed Unit.

Qualifications:
- A minimum of two years nursing practice experience in this Nursing Specialty.
- Advanced educational preparation in this Nursing Specialty and/or Nursing Administration — a baccalaureate nursing degree preferred.
- Eligible for registration in Manitoba.

Our hospital is a 433 bed complex including Intensive, Acute, Maternal-Child, Rehabilitation, Extended and Ambulatory Services.

Interested applicants are requested to submit a current resume outlining experience and educational history to:

Director of Employee Services
Brandon General Hospital
150 McTavish Avenue East
Brandon, Manitoba
R7A 2B3

NURSING DIRECTORS

required for

Medicine Hat and District Hospital

This is the active treatment, rehabilitation and extended care portion of a 567 bed total health care complex in Medicine Hat, Alberta.

A complete reorganization and major expansion of all facilities of the 247 bed active treatment hospital is in progress with concomitant organization of nursing care programs. Medicine Hat & District Hospital is involved in a number of pilot projects in Alberta.

Positions Open
(1) Clinical Nursing Director - Active Treatment Centre
(2) Inservice Director - Staff Development

These are senior nursing positions. Directors report to the Assistant Executive Director - Patient Services.

A cross appointment in the college nursing program may be recommended.

Qualifications
A Master of Science Degree in Nursing is preferred.

Advanced clinical knowledge and expertise are required.

Salary
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Submit Resume To

Mrs. Gwynneth Paterson
Assistant Executive Director - Patient Services
Medicine Hat & District Hospital
666 Fifth Street, South West
Medicine Hat, Alberta
T1A 4H6

DIRECTOR OF NURSING

La Verendrye General Hospital, 107-bed Acute Care hospital, located on the beautiful International Border at Fort Frances, Ontario requires a DIRECTOR OF NURSING.

The hospital is embarking upon an expansion program, which will include a 37-bed Chronic Ward and Rehabilitative Program. This position provides an excellent opportunity to work with a young administrative team.

Position will include responsibilities for all Nursing Departments, and reports directly to the Administrator.

Applicants should have their Bachelor's Degree in Nursing, and Nursing Administration experience would also be an asset.

Excellent starting salary and fringe benefits.

Reply to:

K. W. White
Administrator
La Verendrye General Hospital
110 Victoria Avenue
FORT FRANCES, Ontario
P9A 2B7

City of Vancouver

Associate Co-ordinator — Community Health Nurse

The City of Vancouver Health Department is seeking a Community Health Nurse to assist in co-ordinating a unit nursing programme for one segment of the City. The Community Health Nurse II will plan, train and counsel nursing staff and assist in the administration of the unit. Considerable focus will be placed on responding to the needs of the community and to developing nursing staff in order to provide better nursing services.

Qualifications:
Baccalaureate degree in nursing included or supplemented by training for community health nursing practice and completion of post basic courses in a clinical/functional aspect of nursing. Preferably a Master's degree with a major in the area of clinical/functional expertise. Some experience as a Community Health Nurse.

Salary:
$1380 — $1638 per month (1975 rates) depending upon qualifications and experience.

Applications should be obtained from and returned, preferably together with a detailed resume of education and experience, to the Director of Personnel Services, Vancouver City Hall, 453 West 12th Avenue, Vancouver, B. C. Please quote competition number R-1860.

APPLICATIONS ARE INVITED FOR THE POSITION OF

EXECUTIVE DIRECTOR

The Executive Director is responsible for the administration of a staff of 35 persons involved in the statutory functions and professional affairs of the provincial association. This includes activities related to registration of nurses, educational and nursing practice issues, and communication with members, the public, government officials and others.

Applicants should have a broad nursing background, proven administrative ability and university preparation, preferably at the master's level. Eligibility for registration in British Columbia is essential.

The successful applicant will serve as Assistant Executive Director on an interim basis from August 1, 1977. The interim appointment will continue until the retirement on September 1, 1978, of the incumbent Executive Director.

Inquiries and confidential applications which include resumes and salary expectations may be submitted to:

Search Committee
Registered Nurses' Association of B.C.
2130 W. 12th Ave.
Vancouver, B.C. V6K 2N3

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For two of the positions it is essential to have current expert knowledge in medical and surgical nursing, and for one of the positions in paediatric nursing.

Relevant teaching experience would be an advantage.

For all positions it is essential to be eligible for registration as a nurse in the State of Victoria.

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All other positions: A Degree in Nursing is desirable, but applicants with other Degrees and/or Diplomas who have relevant nursing experience, may be considered.

Appointments are available on a long term basis or, if desired, on a 2-3 year teaching contract basis.

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Closing date for application is June 17, 1977.
Appointees are expected to take up duties after 1st July, 1977.

Applicants should forward a curriculum vitae, including personal details, qualifications, experience and references to the Staffing Officer (Ref. 225), Preston Institute of Technology, Plenty Road, Bundoora, Vic, 3083, Australia.

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requires
Senior Teacher
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Position
Challenging teaching position available immediately for one year post-basic Intensive Care Nursing Course planned for staff working in Medical-Surgical Intensive Care Units in two University-affiliated hospitals.

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- collaborate with nursing service to improve patient care.
- participate in didactic and clinical teaching and evaluation of student progress.

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Salary commensurate with experience and education.

Interested applicants apply in writing to:

Manager Employment & Training
Manpower Division
Health Sciences Centre
700 William Avenue
Winnipeg, Manitoba
R3E 0Z3
Closing Date: May 27, 1977

Director of Nursing - Psychiatry
University of British Columbia Health Sciences Centre

Applications are invited for the position of Director of Nursing for this progressive university psychiatric unit offering a variety of inpatient and outpatient programmes. This 60-bed unit is part of a projected 600-bed university health sciences centre complex. The position of Director of Nursing offers a challenging opportunity to exercise administrative skills in collaboration with colleagues from a variety of disciplines. An appointment in the School of Nursing accompanies this position.

Qualifications:
Candidates should have a Master's degree in nursing with considerable administrative and clinical experience in psychiatric settings. Candidates must also be eligible for licensure in British Columbia. Salary will be commensurate with qualifications and experience.

Please apply c/o:

Dr. Beverlee Cox, Chairperson
Search Committee
University of British Columbia
School of Nursing
Vancouver, B.C.
V6T 1W5

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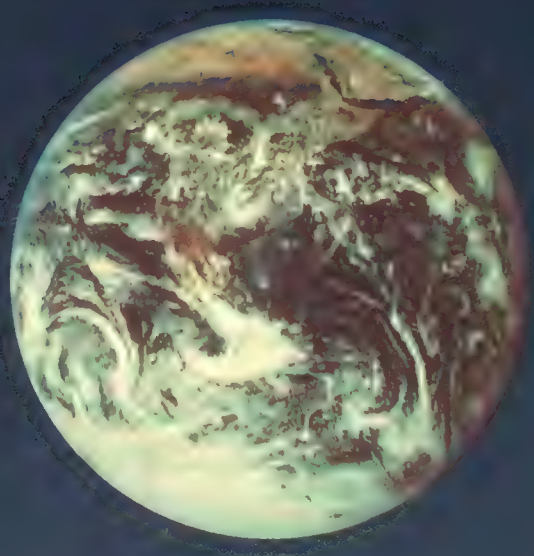
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the canadian nurse

June, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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That's camper Norbert Kratz smiling at you from the cover of this month's issue. Norbert was a camper at C.F. — Camp Couchiching, a camp for adolescents with cystic fibrosis. The author of Four Summers, J. Karen Scott, has been nurse-in-charge of C.F. — Camp Couchiching since its opening four years ago. Karen shares some of her experiences with you in an article beginning on page 14.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

World Environment Day — June 5, 1977

The United Nations Environment Programme, established by the UN in 1972 and now located in Nairobi, Kenya, points out that:
The environmental crisis has different causes in different parts of the world. In some nations it is the result of inappropriate development; in still others, a result of under-development. Logically, the symptoms of the crisis will vary tremendously around the world: in one area desertification, in another contamination of water, in yet another energy waste. Throughout the world, however, there is one clear message — sustainable development is impossible if we are insensitive to our environment.

This month we opened up our summer cottage in preparation for the warmer months ahead. Each year this time-honored ritual gives me a quiet satisfaction that lies almost forgotten in my subconscious mind until next year's performance reminds me again just how closely I am bound to this particular few acres of rocky land with its pine trees and bit of sandy beach. This year I thought "this is what people mean when they talk about your own space and getting to know that space."

After nearly four decades, there is not a sound in that space that I can't identify — from the whir of a partridge on the hillside to the peeping of the spring frogs. Not a rock I haven't stubbed my toe on at one time or another. Not a tree whose growth I can't measure against the year before.

Yes, this is my space and I know it well. I can walk its paths on a moonless night and find my way among its natural obstacles.

This year as I renew my knowledge of my space I wonder about the space that children of the next generation will inherit. I think of the population centers of the world — Tokyo, New York, London — of the way our own Canadian cities have grown more crowded in recent years.

I remember that even now the provincial government is debating whether or not to ban sport fishing in this lake and hundreds of others like it in the province. A document prepared by the Ministry of Natural Resources and submitted to the Cabinet last summer is supposed to have warned that if it continues to permit fishing for contaminated species "some of the public will conclude the Government has no concern for the health of the general public."



Photo by L. Vanfasette

I remember, too, that less than 25 miles away the residents of a small town spent last winter fighting attempts to turn the outskirts of their village into a dumping site for nuclear waste.

I wonder how many of the cottages on our lake have inadequate waste disposal systems and how many cottage owners will neglect to send a sample of the water from their well for testing this year.

I remember that back at home there is a strong probability that none of the dozen beaches in the immediate Ottawa area will be open for swimming this year.

Wherever it happens to be, each of us has a space that is uniquely ours but our position in that space can no longer be taken for granted. Our environmental resources, like our own physical resources, are finite; they are ours to enjoy and to pass on to our children only to the extent that we preserve and protect them and teach our children to do the same.

— M.A.H.

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Herein

One of Canadian novelist Margaret Atwood's earliest works, "The Edible Woman" concerns itself with "the problems of a young woman who, a willing member of a consumer society, suddenly finds herself identifying with the things consumed." The heroine, Marian, tries to describe what has happened to her: "I can't eat certain things; I get this awful feeling ... things I used to be able to eat. It isn't that I don't like the taste; it's the whole ..."

Self-starvation holds a degree of fascination for all of us but it is of special interest to nurses who find themselves caring for a victim of Anorexia Nervosa — like the nurses in Vancouver who wrote the article that begins on page 22 of this month's issue.

Congenital dislocated hip is a significant condition affecting 1.5 to 1.7 infants of every 1,000 born. Unless treated very early in the infant's life, it has the potential to become a seriously crippling disability. **Next month,** author Celia Nichol talks about early signs of the disease, its treatment, and the supportive and practical ways in which a nurse can help parents of a child with CDH.

The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Editor's note: *The following letter from the Commissioner of the federal Law Reform Commission was received by the executive director of the Canadian Nurses Association following a meeting in mid-April.*

Protection of life

The Law Reform Commission of Canada will be undertaking a series of research studies on the protection of human life with a view to ascertaining whether or not the present law, and more particularly the criminal law, can adequately meet the challenges created by modern medicine and science.

It is hoped that these studies will also serve to encourage a frank dialogue between the various segments of the Canadian population on certain topics which, as presented by the press, are often misunderstood or over-simplified due to ignorance of many of the relevant implications and complexities.

The project is entitled, *"Protection of Life,"* and will have a life span of at least three years in its first phase.

This first phase will center around four major issues:

- *Legal definition of death:* Should the law define death for legal purposes?
- *Euthanasia:* The right to refuse treatment, the right to "die with dignity," the termination of extraordinary means of life support, etc.
- *Human experimentation:* Its legitimacy, its limits, the ways of control, etc. ...
- *Behavior and personality control:* Psychosurgery, drugs, aversion therapy techniques; their legitimacy, their limits, etc. ...

Other research will be done on subjects, such as homicide, informed consent and the philosophy of our criminal law on the protection of the human person.

I am aware that these subjects are of direct interest to nurses. Their privileged position in health care has made them acutely and directly aware and exposed to most of these problems, both in their human and scientific dimensions. The opinions, suggestions and reactions of nurses would for that reason be very useful to us.

On the other hand, in order to be accurate, credible and convincing, this research and our eventual proposals must be based upon *precise facts*. It is therefore of utmost importance to us to determine what exactly are the current practices and procedures in Canada in the subject areas indicated above.

We would be happy to consult and hear from you. Individual Canadian nurses should communicate with their national association directly. I might add that I and the members of the project staff would be very willing to travel to various regions of Canada for purposes of consultation, should you deem it advantageous.

— Jean-Louis Baudouin, Commissioner, Law Reform Commission, Montreal, Qué.

A gut reaction

I would like to add my name to those who are uncomfortable with your present policy of using bare surnames in *The Canadian Nurse*. I get a very uncomfortable "gut feeling" when this happens especially if this relates to someone I especially admire and hold in high esteem i.e. Dr. J. Flaherty or Dr. M. Allan.

To me the use of surnames only is depersonalizing and disrespectful. I am reminded of an instance when I was a head nurse on a psychiatric unit. A new student nurse on affiliation wanted to get the attention of a psychotic patient at the other end of the corridor. She simply yelled "Brown, come here." I have never forgotten the look of shock on that lady's face.

Like Bonnie Hartley I have not adapted to the use of surnames only, as I expected I would eventually. I sincerely hope this practice can be changed.

— Ivy H. Dunn, Ottawa, Ontario.

Congratulations!

Many changes have been noted. The covers are colorful; the articles are informative and challenging; the news items are exciting and a means of good communication.

Best wishes for continued success to you and your staff.

— Betty MacEachern, B.N., Associate Director of Inservice Education, Prince Edward Island Hospital, Charlottetown, P.E.I.

The natural way

I am disturbed by the conclusion of.Fetal Monitoring— Why Bother?" (March, 1977): "the evidence in favor of *routine* fetal monitoring is strong."

This article includes, as part of the evidence, a table of 1973 Perinatal Mortality Statistics showing Canada behind seven other countries. (Six of these countries also had lower Perinatal Mortality Statistics in 1971 when Canada was fifteenth).

Surely if we are trying to "ensure the welfare of our unborn children" we should look at the childbirth practices of these countries. Without exception, the outstanding feature is the conspicuous absence of drug-induced labors, fetal monitors and other tinkering with the natural process of normal births. This combined with prenatal training for both parents and good support by professionals would appear to offer more hope for a healthier, happier childbirth experience and outcome for all concerned.

— Meg Purdy, North Bay, Ont.

Hemophilia society

As national president of the Canadian Hemophilia Society, I am writing this letter in the hope that we can locate all persons afflicted with this condition.

Hemophilia can be a crippling, life-threatening disease unless prompt and adequate care is received. In the last few years, new blood concentrates and methods of treatment have been announced which can lead to a fully productive life. The only barrier is knowledge.

We wish to encourage hemophiliacs, or anyone knowing a hemophiliac, to contact us.

During the summer of 1977, we will be conducting a nationwide project to ensure that all hemophiliacs are made aware of current treatment methods. All information thus obtained will be confidential.

To help us control this crippling disease, contact us immediately.

— Ronald E. George, President, Canadian Hemophilia Society, Chedoke Centre, P.O. Box 2085, Hamilton, Ontario, L8N 3R5.

Offensive ads

I am a community health nurse who finds at least one article in eac issue of *The Canadian Nurse* that ha direct application to my work. Other are helpful in updating general knowledge and nearly all are of interest to me..

I am disturbed by the fact that in the March issue two advertisements appeared which I find offensive. On of these shows two nail-polished braceleted young women wearing nurses' uniforms. Another shows a child dressed as a nurse encouragin us to buy shoes.

Please, nurse are adult professional people. We should neve forget that and nor should our magazine. I am appalled that *The Canadian Nurse* accepts such advertising.

— Heather J. Leighton, R.N., Vancouver, B.C.

Making hay ...

I was disappointed to read in " Program that Dares to be Different" (March, 1977) that Okanagan Colleg has fallen into the trap of making summer semester work in a nursin setting *compulsory*. While I would never discourage a student from working in a hospital during her vacations, I would also assure her th there are many other activities and types of work which will not only he her mature, but also broaden her horizons.

I think teachers have a responsibility to encourage studen to use their youth and zest for life to travel, try new activities, and question their goals before they become locked into full-time employment. There's always time after graduation to perfect manual dexterity and efficiency!

— Margaret L. Wray, R.N., B.N., Ob./Gyn. Nursing Instructor, Montreal, Quebec.

On the bright side

...The facelift surely makes th magazine attractive. It gives you a feeling of anticipation about the go reading inside. However I would like to make a suggestion: how about a pa or two devoted to the funny experiences that nurses have?

— A. Catindig, R.N., Windsor, Ontario.

When you rely on Saunders texts . . .

The Nursing Clinics of North America

These quarterly symposia keep you informed on the most important changes in clinical nursing practice. The March 1977 issue focuses on *Peripheral Vascular Disease* with Dorothy L. Sexton as guest editor; and on *The Minority Patient: Cultural and Racial Diversity.* Other 1977 symposia will discuss: *Primary Nursing; Diseases of the Liver; Patterns of Parenting; Diabetes;* and other vital nursing topics.

By respected nursing authorities. Published quarterly: March, June, Sept., and Dec. Hardbound. Contains no advertising. Averages 185 pp. Illustd. $18.90 per year's subscription. (Subscriptions can be obtained at a saving of $1.60 by sending a check for $17.30 along with your subscription request.)
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STRYKER: Rehabilitative Aspects of Acute and Chronic Nursing Care, *New 2nd Edition*

In this particularly thorough revision, the author has integrated important information on geriatrics into every chapter. She also has included new chapters on Maintaining Human Sexuality, and The Elderly in the Community, as well as vastly increasing the pertinent coverage of *psychological reactions to physical disability, planning patient care, communications disorders, assisting with bowel and bladder problems,* and *positioning and skin care.*

By **Ruth Stryker,** RN, MA, School of Public Health, Univ. of Minnesota, Minneapolis. About 305 pp., 105 ill. About $11.30. Ready June 1977.
Order #8637-0.

Du GAS: Introduction to Patient Care, *New 3rd Edition*

This brand new edition contains additional material on the *health care system, major health problems,* and *the role of the nurse.* Entirely new chapters on Nursing Practice, Communication Skills, and Sensory Disturbances, more than 70 new photographs, and its considerably expanded glossary make this revision an even better text to learn the fundamentals of nursing. A Teacher's Manual will be available.

By **Beverly Witter Du Gas,** RN, MN, EdD, LLD, Health Science Educator, Pan American Health Organization, Barbados, Regional Allied Health Project. About 685 pp., 240 ill. (78 in color). About $12.40. Ready June 1977.
Order #3226-2.

LEIFER: Principles and Techniques in Pediatric Nursing, *New 3rd Edition*

This comprehensive clinical nursing text and reference bridges the gap between theoretical knowledge of and practical skills in pediatric nursing. Completely up-dated and substantially expanded, you'll find added coverage of *new equipment, inhalation therapy, dietary considerations, poisoning, drug interactions,* and a whole new chapter on The Pediatric Outpatient and the Clinic Nurse.

By **Gloria Leifer,** RN, MA, formerly of Hunter College of CUNY. 321 pp. 184 ill. April 1977.
Hard cover: $9.25. **Order #5713-3.**
Soft cover: $7.75. **Order #5719-2.**

SAUVÉ & PECHERER: Concepts and Skills in Physical Assessment

This book can save you valuable time in teaching the basics of physical examinations. It's a modular syllabus for self-study (with instructor guidance). Each of its 23 units includes a pretest, glossary, clinical component, a self-test, response sheets, and handy reference cards for use during actual examinations. This outstanding text is a perfect adjunct to a wide range of learning activities. An Instructor's Guide will be available.

By **Mary Jane Sauvé,** RN, BSN, MSN, Asst. Prof. of Nursing, Calif. State College, Sonoma, Rohnert Park; and **Angela R. Pecherer,** RN, BSN, MSN, Asst. Prof. of Nursing Education, Intercollegiate Center for Nursing Education, Spokane, Wash. 427 pp. Soft cover. $11.30. Feb. 1977.
Order #7939-0.

WOOD & RAMBO: Nursing Skills for Allied Health Services, *New 2nd Edition*

Reorganized and thoroughly up-dated, this new 2nd edition gives explicit instruction in *problem-oriented charting, patient rights, informed consent, care of the dying patient, methods of calculating the drip rate of intravenous infusion,* and much more. For example, the section on care of the colostomy patient now includes *procedures used in changing disposable colostomy bags, the use of permanent stoma bags,* and *simplified irrigation procedures.* Teacher's Guides will be available.

Edited by **Lucile A. Wood,** RN, MS, Director of Nursing, Bay Area Hospital, Coos Bay, Oregon; and **Beverly J. Rambo,** RN, MN, Mount St. Mary's College, L.A.; with four consultant writers. About 830 pp., 500 ill. Soft cover.
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By **Lisa Robinson,** RN, PhD, Univ. of Maryland School of Nursing; and School of Medicine, Univ. of Maryland. 459 pp. About $10.30. Just Ready.
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News



Jocelyn Hezekiah



Irmajean Bajnok

RNAO delegates prepare now for future shock

The many faces of reality — 1977 style — were the object of close scrutiny by close to 1200 Ontario nurses and student nurses who attended the 52nd annual meeting of their professional association in Toronto April 27 to 30. On the minds of the RNAO members were a variety of immediate concerns that will have a direct bearing on the future of nursing practice in that province.

Acting on these concerns, delegates gave their collective approval to:

- collaboration with the medical profession in plans to improve the province's health care delivery system;
- an educational program to inform the public of the RNAO's historical position supporting the principle of collective bargaining for nurses and the association's role in the establishment of the Ontario Nurses Association;
- protection of the public in the area of non-prescription and over-the-counter drugs;
- efforts to amend the new Ontario Health Disciplines Act to provide for a clause governing conflict between the professions and to reach an agreement with the medical profession on the transfer and delegation of medical acts to nurses;
- action by the Board urging the Ministry of Health to more effectively utilize community health workers in the promotion of health and prevention of disease;
- recognition of public health, visiting nurses and occupational health nurses as essential health care workers;
- a program of public action advising the consumer of the advantages of receiving professional care given by RNs and RNAs;
- amendment of regulations under the Public Hospitals Act to ensure that hospitals employ only RNs, RNAs and/or nurses and nursing assistants whose registration is pending;
- assuming leadership in sensitizing health professionals to moral and ethical issues related to Protection of Life;
- participation in revision of Standards of Nursing Practice at provincial and local levels.

In addition, delegates learned that two official statements concerning the RNAO position on the role of the nurse as a patient advocate and competency in cardio-pulmonary resuscitation had been approved by members of the Board of Directors at a meeting the day before the conference opened. The statement on cardio-pulmonary resuscitation supports the College of Nurses in its stand that all registered nurses must possess competency in resuscitation measures, including artificial respiration (mouth to mouth) and external cardiac massage. Basic life support was declared a first aid procedure rather than a medical act in Ontario in November, 1976.

Citizens' Council

Helping nurses to keep in touch with reality in the future will be a Citizens' Advisory Council whose membership includes a cross-section of men and women from education, business, the community, labor and media. In announcing the names of the new council members, RNAO president Norma Marossi said:

"Input from the council is one way we will ensure that the nursing profession stays in tune with today's needs. Members were chosen from individuals who, because of their particular interest, experience and background, can provide guidance thereby ensuring that the Association and the profession remains aware of and up-to-date on the health needs and concerns of the community." The council will hold its first meeting in the Fall.

RNAO members learned during the meeting that **Maureen Powers,** director of nursing at the Eastern Ontario Children's Hospital in Ottawa, had been named to succeed Laura Barr as executive director of the association. Powers will assume responsibility for this position September 6, 1977. (See page 12)

Dealing with the realities of achieving social change was the topic of guest speaker **Aileen Nicholson, MPP,** at the luncheon held on the closing day of the convention. She told the nurses in her audience that they should make better use of the advantage provided by their professional training in dealing with politicians. "Nurses learn early to combine the use of authority with being helpful but the same easy, pleasant assurance that characterizes the nurse-patient relationship is not always apparent in their work as advocate on behalf of these same patients." Nicholson went on to outline a number of tips members of professional associations might consider in order to increase the effectiveness of their politicking. These included: dealing openly and amicably with the government of the day, "even if it is not your favorite political party," getting to know the civil servants concerned, and developing on-going constructive relationships with various levels of government to whom briefs are presented.

Briefs, she stressed, should be based on systematic analysis and incontrovertible facts. They should offer constructive solutions and, most important, specific alternatives on contentious issues. "In conclusion," Nicholson said, "don't let anyone tell you that you are politically inexperienced. If you have mastered hospital or university politics, parliament will present no problems."

At the conclusion of the convention, **Irmajean Bajnok,** was installed as president for the coming biennium. The new president is assistant professor in the Faculty of Nursing at the University of Western Ontario. During the convention, delegates also elected a new president-elect for the 1977-79 biennium. She is **Jocelyn A. Hezekiah,** chairman of the basic nursing program, Humber College of Applied Arts and Technology in Toronto.

Outgoing president **Norma Marossi,** in her address to delegates, stressed the unique position of RNAO among the other ten member associations of the Canadian Nurses Association because of the jurisidictional split between the RNAO, the College of Nurses and the Ontario Nurses Association. Leaders and members of these three groups, she said, should periodically pause to discuss their respective objectives, the relevancy of their programs and accountability to members. "While the goals of the three groups may vary," she said, "We are members of the same league. We must continue to demonstrate that this tripartite model effectively serves the citizens, the nurses and the profession in Ontario."

Marossi called on nurses in the province to develop a "comprehensive quality assurance program" encompassing standards of nursing care, nursing education, performance appraisal programs, objective measurement of quality of care, maintenance of competency and professional accountability. She described the proposed program as "probably too grand and too important to be attempted by any *one* body in isolation" but stressed that the RNAO should "take its rightful role of leadership and coordination."

Speakers at the concurrent sessions on health and social issues were: Shirley Wheatley, supervisor of Family Planning Services, Department of Public Health, Toronto; Frederick Funston, consultant, Addiction Research Foundation; Catherine MacGregor Keyes, director, Public Health Nursing, Ottawa-Carleton Regional Health Unit, Ottawa; Karyn Kaufman, clinical nursing specialist, McMaster Medical Centre, Hamilton.

"The individual copes with today's realities" was the subject of a growth and development session led by two nurses, **Gail Donner,** chairperson, Nursing Department, Ryerson Polytechnical Institute in Toronto, and **Paula Goering,** an instructor in the Faculty of Nursing at the same school.

An international overview of nursing care was presented to the delegates by the third vice-president of the International Council of Nurses, **Verna Huffman-Splane.** Splane, who is currently a special lecturer on national and international nursing at the University of British Columbia's School of Nursing, reminded her audience that "more than half of the world population now receives either minimal or no health care."



Toronto O.R. Nurses

Coping with Cancer: a symposium for everyone

A three-day Symposium on Coping with Cancer brought over 400 people from all parts of Canada to Toronto in April. The meeting, sponsored by the Canadian Cancer Society, involved members of the medical, dental and nursing professions, social workers, theologians, and volunteers and staff of the Canadian Cancer Society, who met to take a comprehensive look at the many special problems related to coping with cancer.

Prevention was the first aspect of cancer to be discussed, with lay education, industrial environmental problems and screening being major considerations. The remainder of the conference dealt with the most effective ways to help the cancer patient and his family, and it included discussions on emotional problems of those who work with cancer patients on a voluntary or professional basis.

The often neglected human aspect of cancer treatment was perhaps best presented by Henry Viney, a radio and television sportscaster from Calgary, Alberta. His wife died of cancer two years ago. Beginning "...Mine is not a pleasant story," Viney described his painful inability to support his wife when they both realized that she was dying of cancer "...and we both knew, and still never discussed death."

Viney expressed the hope that perhaps his story might help others to do a much better job of supporting the cancer patient and his family than he had been able to do. A social worker, a patient, a family physician and an oncologist discussed their approaches to helping the newly diagnosed cancer patient.

The practical problems of the individual who has been successfully treated for cancer were also considered from a number of standpoints. Emotional adjustment, employment, insurance and rehabilitation, and the role of self-help groups were discussed by those involved in each sphere of cancer recovery.

The conference also provided an afternoon to discuss helping the patient and family when curative measures fail. How to tell the patient was just one of the concerns discussed. Palliative care, the role of the clergy, the role of the friend and family, were also considered.

Mary Vachon, a nurse and sociologist with the Clarke Institute of Psychiatry spoke about the stress widows face when their husbands die of cancer, those who must stand by helplessly as their husbands cope with pain, deterioriation, and the threat of impending death. She spoke about the feeling that these women have of being left on their own as death approaches. The information that she gave came from the first in-depth study of Canadian widows, a study of Canadian widows, a study carried out so that professionals could change their approach to prevent or alleviate suffering for future patients and their families.

Topics for discussion were arranged in units, and each topic was followed by a question period, so that those attending the conference were able to voice their concerns about coping with cancer. Certainly the symposium met its objectives by increasing the knowledge of the delegates with regard to the broad spectrum of problems surrounding cancer, increasing their knowledge of social and economic rehabilitation of cancer patients, and providing a forum for continuing education.

NLN elects man as vice-president

The National League for Nursing in the United States (NLN) has, for the first time in its 25-year history, elected a man to the position of president-elect. Matthew F. McNulty whose election was announced during the League's recent convention and exhibition, is chancellor of the Georgetown University Medical Center in Washington, D.C.

The new president of the NLN is Sylvia R. Peabody, executive director of the Visiting Nurse Association of Detroit.

The NLN has its headquarters in New York City and is a membership organization dedicated to meeting the health needs of the people by improving nursing education and nursing service.

OR nurses hold 10th conference

Approximately 500 nurses from across Ontario, other parts of Canada and some areas of the U.S. met in Toronto to attend the Tenth Conference of the Operating Room Nurses of Greater Toronto held April 25-27. Those at the meeting took a look at topics of current interest to the O.R. nurse — what O.R. nursing is now and what it could be in the future.

The conference, opened by Mary Wakefield, began with a panel discussion and question period that looked into the problems of working in a smaller hospital and trying to prevent duplication of services, the difficulties in setting up operating rooms in a new hospital, how it 'feels' to be an O.R. staff nurse and, from the government side, the problem of cost containment in health care generally.

A wide variety of topics were discussed at the three-day meeting, everything from the latest developments in reconstructive surgery to a look at "working relationships" in the O.R. between nurses and doctors. Nurses also had an opportunity to speak with over 60 suppliers and manufacturers of O.R. equipment and to see their newest products on the market.

The Operating Room Nurses of Greater Toronto started as an interest group in 1959. Now, with approximately 185 members they hold educational meetings four times a year, and larger conferences every one or two years. Their most important project to date has been the publication of a booklet on standards of practice for operating room nurses. Two-and-one half years ago, a Standards committee, headed by Faye Trouten, was formed representing seven hospitals in the Toronto-Hamilton area. Members of the group were (from left to right, front to back): *Pat LeBlanc, Carol Potter, Norma Williamson, Mable Kotyk, Flo Bestic, Faye Trouten, Mary Barnes. (Absent: Margaret Porter, Helen Gibson, Bev Schmocker).* The booklet will serve as a useful guideline for any operating room wishing to establish standards of practice on which to evaluate staff competency.

For copies, send $2.50 to: Mrs. Jean Mitchell, President, Operating Room Nurses of Greater Toronto, North York General Hospital, 4001 Leslie Street, Willowdale, Ont. M2K 1E1.

Operating Room Nursing groups are active in every Canadian province and will be meeting together next year in Halifax at a national convention.

NBARN presents brief to education committee

No major changes are needed in the New Brunswick nursing education system according to the province's professional nursing association. The conclusion is contained in a brief presented recently by the New Brunswick Association of Registered Nurses to the Maritime Provinces Higher Education Commission.

The brief points out that New Brunswick now offers two types of nursing education programs, the two-year diploma and the four-year university. These programs are provided in educationally-controlled institutions and in both languages. According to the brief, the past year has marked the end of an era in diploma nursing education, with the completion of the transition from three-year to two-year nursing schools.

Although the present system is adequate and able to meet the challenges of evolving health services, according to the brief, there is work to be done to improve the quality and relevance of the programs. This is an on-going process and one that is basic to the fundamental purpose of the NBARN.

NBARN officials identify a number of concerns in the brief, including the number of applicants to schools, especially French-language applicants; facilities for the Saint John School of Nursing; high cost of education for university nursing students; supportive research; continuing education for nurses; and nursing manpower and the employment situation.

News



A group of Canadian delegates to the 1977 Annual Meeting of the American Association of Neurosurgical Nurses, held at the Hotel Toronto in April. The Keynote Address for the meeting was delivered by the Honorable Pauline M. McGibbon, Lieutenant-Governor of Ontario, to about 400 members of the A.A.N.N. from all parts of the United States and Canada. The meeting was educational in nature, covering a number of concerns faced by nurses working in neurological and neurosurgical units. It was held in conjunction with a meeting of the American Association of Neurological Surgeons. (Photo by S. Emond)

Roundup of critical issues

CNA's March annual meeting wound up on a lively note with a panel discussion by five members of CNA's Executive Committee.

The discussion, entitled "Critical Issues in Nursing," was moderated by second vice-president **Sheila O'Neill** of Montreal. Each of the four panel members identified developments particular to their area that they viewed as crucial to the future of the nursing profession.

Helen Glass, of Winnipeg, Manitoba, began the discussion by identifying the need to examine all present levels of nursing education (including continuing education) with the aim of incorporating change where necessary. She brought to light a number of questions facing nursing education now, questions involving the direction it will take, questions that need answers that will keep in mind the needs of the student and the needs of society. One of the present problems, she said, is the lack of graduate schools for teachers or practitioners in Canada.

Barbara Racine of New Westminster, B.C., member-at-large for nursing administration, spoke of the important questions facing nursing administration in a decade when nurses "had taken the starch out of their uniforms and put it into their backbones." She said that the present tendency to compartmentalize within the nursing profession — for example into management and union — had to be overcome by recognizing internal indicators, those aims that are common to all nurses. She spoke of the necessity for the nursing administrator to use her powers in the best interests of nursing and the patient. This could involve defending the nursing budget in the face of government cutbacks, using a position on a hospital board to express the needs of her staff and concerns for standards of care, and using a collective contract as a legal means to hold nursing accountable.

Linda Gosselin of Thunder Bay, Ontario, member-at-large for social and economic welfare, also spoke of the need for a resolution of conflicts between nursing management and staff. The solution to the problem between the two sides of the bargaining table, she said, lay in the realization that "we are all on the same team," with the same goal, quality patient care.

Member-at-large for nursing practice **Lorine Besel** of Montreal, discussed the moral issues presently confronting nursing practice. Her concern about fragmentation of nursing care, professional honesty, and the moral issues of nursing, was beautifully illustrated through the use of a case study of a particular patient and the involved response of a student nurse.

B.C. nurses accept two-year contract

Nurses employed by the provincial government have voted by 96 percent to ratify a 1976-77 contract negotiated with the B.C. Government Employee Relations Bureau (GERB).

The April ratification vote marked the end of 18 months of on-and-off negotiations. In March the nurses threatened strike action before GERB would resume the negotiations it had broken off in December. The 2,600 nurses have been without a contract since October 31, 1975.

The two-year agreement is worth 14 percent, the maximum allowed by federal anti-inflation guidelines, averaging 8 percent for 1976 and 6 percent this year. The compensation package is a combination of salary increases, benefits and cash payments.

The agreement covers 1,600 registered psychiatric nurses and 1,100 registered nurses working in provincial government psychiatric facilities and public health units throughout the province. They are represented jointly by the Registered Nurses' Association of B.C. and the Registered Psychiatric Nurses Association of B.C.

Alberta nurse educators form new association

Directors of nursing in the province of Alberta have joined forces to facilitate improvements in education programs in their province. The name of the new group is the Consortium of Nurse Educators (COSNE). Its members are the persons responsible for administration of professional nursing education programs in the 13 Alberta institutions that offer diploma, baccalaureate or graduate programs in nursing.

The purpose of COSNE is to provide an opportunity for members to share ideas, act as a resource group and provide direction to appropriate bodies in matters related to nursing education in the province of Alberta. Contact is invited and may be made through any member or the current chairman, Shirley Shantz, Coordinator-Nursing, Red Deer College, Red Deer, Alberta.

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News

Family life delegates examine health care

One of the major stumbling blocks in the path of development of an effective health care system in this country is a tendency to define the *caring function as existing only outside the family*. "Health policy and practice," according to a University of Calgary professor in the faculty of social welfare, "is oriented to the needs of the individual and perhaps even more to the type of care and method of practice which most suits the health professions."

Professor Andrew Armitage was one of two keynote speakers opening up proceedings of a three-day conference on Family Policy in Ottawa, April 24 to 26. The conference, sponsored by the Canadian Council on Social Development, was attended by more than 350 representatives of social service agencies across the country.

In a background paper prepared for the conference, Professor Armitage points out that the remnants of the family support system remain with the public health services — clinics, school health services, home visiting and care programs. "But public health is the poor relation in the health field and, further, it tends to arouse professional opposition when it tries to extend its role." Professor Armitage believes there are indications in the 1970's of a return to more family based health care although "impulses at the political level seem to have come from escalating health costs rather than a conviction about family policy. Arguments in favor of family health care," he says," have been used to 'sweeten the pill' for opponents of change."

He cites as examples of renewed interest in family-oriented care, the new status of public health programs, particularly those geared to health promotion, the development of community health centers, and attempts by the medical profession to upgrade family practice. He says that although home care programs are gradually being extended to assist the chronically ill, "there is as yet no policy of consistent support to enable the family to deal with illness and continuing stress."

Dr. Fred R. MacKinnon, deputy minister of social services for the province of Nova Scotia, also stressed the importance of a "familial approach" to public policy in his closing address to the delegates. Such an approach, he said, implies caring and sharing, whereas the economic system is based on competition and the acquisition of material wealth.

The president of the Vanier Institute of the Family, Dr. MacKinnon said that "by their very nature, social services cannot be more effective than the dominant institutions in promoting healthy personal and familial development." He suggested that our goal should be to "maintain and build self-reliance and self-respect which help to make us full persons instead of creating dependence and destroying what little we have of dignity."

Five sub-plenary sessions were held during the conference on the topics of housing, income security, personal social services, health and social justice. The speaker at the health session was former CNA president, Huguette Labelle, director general, Policy, Research and Evaluation Branch Department of Indian and Northern Affairs in Ottawa.

ARNN launches status study

The Newfoundland nurses' association has launched a province-wide study of the status and environment of members of the profession.

The investigation is intended to:
1. promote job satisfaction among nurses;
2. promote decision-making among nurses;
3. provide a mechanism through which nurses can assume a leadership role;
4. enhance the ability of non-nurses to view the nurse as a decision-maker;
5. promote changes in the perspective of other categories of health personnel regarding the role of the nurse;
6. enable nurses to help themselves in improving the quality of their work lives.

The project director will be Clarrie Case. All nurses in Newfoundland will be affected by the study which will involve the use of questionnaires, workshops, educational programs, interviews and observation.

Did you know...
The CNA archives collection of school nursing pins is richer by several fine examples donated by readers since publication of our March cover photo.

Women in ambulance services

The Metropolitan Toronto Departme of Ambulance Services has droppe its height and weight restrictions fo candidates for jobs as driver-attendants after a thorough investigation by the Ontario Human Rights Commission.

Both parties agreed that the ambulance service will devise a mo accurate method of evaluating an applicant's physical capabilities an will consider an on-going fitness program for its employees.

The Ontario Women's Bureau the Ministry of Labour and the Onta Council on the Status of Women ha expressed concern to the Commission last fall over the possib discriminatory effect of the height ar weight requirements on women an some ethnic groups.

In its investigation, the Commission found that Toronto's ambulance service employed no women ambulance driver-attendan in a staff of more than 400. In Januar the Ambulance Services Departme dropped its requirement from 5' 8" a 160 lbs. to 5'6" and 145 lbs.

"They have now dropped the requirement entirely after we demonstrated to them that there is n evidence that a specific height and weight standard is a valid measure any individual's physical capabilities said Naison Mawande, Director of Conciliation and Compliance for th Commission. "We do agree that a standard of physical strength and fitness is a requirement for the job.

Penny Goldrick, an officer of t Commission, found that a good proportion of all the ambulance services in Ontario do not have heig and weight requirements and that some do employ women.

The Ambulance Act now requir a job candidate to take a one-year course, a course now offered in Toronto at Humber and Centennial Colleges, and soon to be available Seneca College. Women are now enrolled in those programs. One of th courses teaches techniques of liftin which reduce the correlation betwee the weight to be lifted and the size sex of the attendant.

(continued on page

Geographical Analysis of CNA Journal Circulation

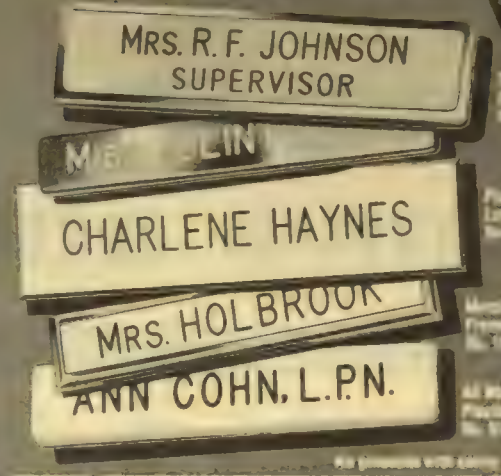
	English	French
Newfoundland	3,197	1
P.E.I.	923	—
Nova Scotia	6,172	10
New Brunswick	4,374	388
Quebec	7,692	36,195
Ontario	21,408	296
Manitoba	7,985	7
Saskatchewan	7,591	6
Alberta/NWT	13,140	27
B.C./Yukon	15,304	21
Total — Canada	87,786	36,951
Outside Canada		
United States	1,667	23
Other*	983	337
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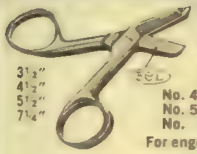
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100	**METAL FRAMED** Smooth plastic background with classic distinctive polished metal frame. Beveled and rounded edges and corners. Smart professional appearance.	Frame ☐ Gold ☐ Silver	☐ White ☐ Ivory ☐ Blue ☐ Brown → ☐ Black ☐ Dk. Blue ☐ White		3 Lines Lettering	☐ 4.29	☐ 6.99
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Names and Faces

CNJ talks to

Maureen Powers

"The Registered Nurses Association of Ontario (RNAO) has to represent the vested interests of all of the various groups within nursing, including such groups as public health nurses, O.R. and psychiatric nurses."

So says Maureen Powers, who was appointed executive director of the RNAO in Toronto on April 28. She will assume office on September 6.



Currently director of nursing at the Children's Hospital of Eastern Ontario in Ottawa, Powers is 35 years old and has gained a reputation for being somewhat outspoken. She says, "I don't like 'stepping on people's toes' but I do try to be very honest in my feelings and in saying those things which I feel need to be said."

"I may be outspoken, or even aggressive, but I would hope I seem reasonable and interested in working out and solving problems through consultation, not confrontation."

Powers says she has always had a great interest in nursing and in nursing concerns. She describes herself as someone who has been "an interested and active member" of her professional association.

Powers is confident of her ability to handle her responsibilities as executive director. She says her present position as director of nursing has given her the experience necessary to know she can "get together with people, be sincerely interested in them and make sincere attempts to represent their interests."

"One of my first objectives as executive director will be to go to individual chapters, meet with groups of nurses and talk to them about the issues which they feel are relevant to us."

From these visits Powers believes patterns of concern will emerge which she, in turn, will point out to the president and the president-elect as directional recommendations.

Powers knows she will meet with difficulties and confrontations over the next few years but says "that's all a part of life and part of working within a successful and healthy organization."

Powers says one thing that she is very concerned about in terms of RNAO is membership. "The RNAO is the professional nurse's association which represents, should represent, all nurses in Ontario."

"I find it very funny when I hear people ask, What can my professional organization do for me? I honestly, and I say this in all modesty, have always asked, What can I do for my professional association? After all, the RNAO depends on me, the member."

"The function of the RNAO, as I see it, is to be a leader and a pacesetter in terms of establishing priorities as to the direction nurses should take. Members are very important in terms of the function of the RNAO and I see myself as executive director taking my direction from the members."

Powers holds a Master of Education (Psychopedagogy) from the University of Ottawa in 1975 and a Bachelor of Nursing from McGill University, Montreal in 1965. She also holds a diploma in maternal and child health nursing and is a 1962 graduate of St. Mary's Hospital School of Nursing, Montreal.

Powers says she finds educational pursuits very exciting.

"Education is important for a nurse's credibility but even more important is the ability to reflect upon what you're doing and to use the resources that other people have worked up. Those are the abilities learned through education and they are very significant in terms of being an effective practitioner."

Powers has worked in pediatrics for many years now and she knows her new position will require her to widen her scope. "I've always been interested in the child, now I'll be concerned with the person at all age levels."

She says it will necessitate different emphasis but she is not worried about making the transition. "I have a genuine interest in health care, and in people and how they will be dealt with in relation to their care."

Powers has loved pediatric nursing and the organization of nurses. She says she will, most definitely, miss the practice of "nursing" (giving care to a patient). But, she also loves nursing itself, and she'd like to be able to contribute to some of the solutions and concerns that nurses are involved with.

Powers believes there is a great need in the profession for people who are "willing to commit themselves and be involved in decision-making about where nursing is going in terms of health care."

Joan Bailey S.R.N. (Barnet General Hospital, England), R.N. (Ontario and Quebec), has been appointed Nursing Officer, The Prior of the Most Venerable Order of the Hospital of St. John of Jerusalem Priory of Canada St. John Ambulance Brigade, Division 178, Margaret McClaren Corp., Quebec.

Joan has had experience in various fields of nursing in Canada, including assistant head nurse in Gynecology, administration nursing supervisor and assistant instructor nursing assistants, general duty staff nurse in Case Rooms and Operating Rooms.



Sharon Dawe R.N. has been assigned to her first post in Latin America where she will help administer the CARE/MEDICO public health auxiliary nurses training program at a hospital in Choluteca, Honduras. She will teach community health, maternal-child health, epidemiology, and nutrition. She had worked in Afghanistan, Algeria, Malaysia and Indonesia prior to her present assignment to Honduras.

Kathy Lauzon has been appointed Executive-Secretary (part-time) of the Canadian University Schools of Nursing (CAUSN).

A graduate of St. Joseph's School of Nursing, Hamilton and of the University of Ottawa (B.Sc.N., B.Ed. and M.Ed.), Lauzon has taught and served as a Coordinator in the Ottawa General Hospital School of Nursing, the Vanier School of Nursing and Algonquin College Health Science Division in Ottawa. Since 1975 to the present, she has been serving as permanent part-time Nursing Coordinator, Obs-Gyn Program, Ottawa General Hospital. Among her other professional activities, she has served as President, Ottawa East Chapter, RNAO (1971-76) and as Ottawa regional representative on the Provincial Executive Committee of RNAO (1972-76).

Anne Marie Snook, a first year nursing student at Memorial University in St. John's, Newfoundland, recently received the Teagle Foundation Scholarship. The scholarship is available to children of employees of Exxon Corporation and is tenable for four years.

FRANKLY SPEAKING

What every reasonable and prudent nurse should know

Nora J. Briant

Lately, in conjunction with a university course that I have been taking, I have been reading a great deal about the issue of mandatory continuing education for nurses. I am writing this article in the hope of getting some response from readers who have opinions about this matter.

When first I began my reading I was in agreement with mandatory continuing education. It just couldn't be right that initial registration should qualify me for a lifetime's practice. When I stopped reading I was convinced that making education mandatory after basic education would serve little or no purpose.

The article that best summed up for me the issues at stake was by Barbara Stevens.[1] Some of the points she makes are as follows: One of the objectives of mandatory education might be to make nurses take up their professional responsibility for learning. However, the problem with nurses who do not do so voluntarily is one of attitude. Making them attend a specified number of educational events to fulfill legal standards will do nothing to give them a positive attitude towards learning.

The objective of providing learning opportunities through mandatory continuing education is not valid either. The learning opportunities could be either a) to stimulate professional growth, b) to update the nurse, or c) to improve job performance. Stimulating professional growth is objected to for the same reason as above, i.e. it will not serve the purpose.

Updating nurses by mandatory controls would be awkward and of questionable value. Who would decide what information is required to keep abreast of changes? Would this information be universally distributed? Does a psychiatric nurse need to know the latest development in urology and does an O.R. nurse teach diabetics? What about the different levels in nursing and the new roles? Improving job performance would require a multiplicity of specific programs only hinted at in the two sentences before. Also, who provides these required learning activities, where, and with what money?

If the objective underlying mandatory education were to improve patient care then extreme difficulties and cost might be acceptable. Again the answer does not suit the problem. Proving that you have been to two courses, a workshop, and a conference doesn't say anything about how much you learned or whether you are applying it. In my reading I did not find any proof that continuing education has a positive effect on patient care. The only guarantee for quality care is to actually assess the care in the clinical setting. None of the laws or suggested laws for mandatory education require this kind of testing and so none of them guarantee improved patient care.

In one article I read that personal reading habits were correlated with the quality of medical care given but attending specific continuing education programs did not correlate.[2] Then I read that the American Nurses' Association Standards for Continuing Education says that general reading, discussion groups and the like do not count as continuing education units because they cannot be uniformly measured.

Mandatory continuing education seems to create a lot of problems and to provide very few answers. We have enough problems now and don't need to spend our energies on ventures of questionable value.

The concern of all authors on the topic was that nurses be accountable to the consumer through continuing education. With knowledge accumulating at great speed and new technologies being developed every day we certainly do need to take part in on-going learning. As for being accountable to the consumer, there should be no worry about that. We *are* accountable and there are no two ways about it. Each of us is expected to do what any other reasonable and prudent nurse in similar circumstances would do or be held liable in a court of law. That is accountability.

There are other ways of maintaining standards besides making laws. At present there is little direct interference by governments or courts in the workings of our profession and I think it is better for everyone concerned if we keep it that way. To do so we must take care of this problem ourselves. Imagine the situation if we did decide that nurses wanting to renew their registration must have proof of, for example, forty continuing education units per year. In provinces where licensure is *not* mandatory, (i.e. B.C., Alta., Sask., Man., Ont., N.B. and N.S.) nurses who did not qualify could still continue to work. An unregistered nurse is not prohibited from practice: she simply cannot use the title 'registered.' At one time it was not uncommon to have unregistered nurses working and we might find that becoming more and more the case if our hypothetical situation came true. Hospitals and agencies desirous of quality personnel might not hire unregistered nurse; but being able to pay them less — they might. Having registration instead of licensure makes mandatory continuing education out of the question.

What can or should we do about standards, keeping up-to-date, professional obsolescence, and the information explosion?

I feel that one good way to help cope with these problems would be to set up voluntary systems of continuing education that would acknowledge participation and achievement. I have read and heard about the American Dietetic Association, The College of Family Physicians and others but I don't think anything of the kind has been available to me. To be a member of one of these societies each person must have taken part in a specified number of courses, workshops, study groups, etc. over a number of years.

The implications of such a membership should be publicized. Then if anyone wants to hire or promote a nurse who is keeping abreast of change and interested in learning they could choose one of these with a degree of assurance. In this way employers and the public would grow to expect high quality nursing care. This demand, combined with the presence of learned societies to encourage and provide educational stimulation, would keep the standard of care up in spite of rapid change in science and technology.

What every reasonable and prudent nurse could be expected to know would be influenced by the educational atmosphere created. I see our provincial associations and educational institutions being potentially the most helpful in establishing these societies and so I aim my suggestions and hopes in that direction.

References

1 Stevens, Barbara. "Mandatory Continuing Education for Professional Nurse Re-Licensure: What are the Issues?" *J. Nurs. Admin.* III:5:25-8.

2 Stuart, Corrine T. "Mandatory Continuing Education for Re-Licensure in Nursing and the Implications for Higher Education." *J.Cont. Ed.Nurs.* 6:5:7-15.

CYSTIC FIBROSIS – CAMP
COUCHICHING... FOUR SUMMERS

J. Karen Scott



Water-skiing instructor (cystic), Hugh Canning, showing his skill by skiing on his feet (no skis).

Usual canoe trip activity, sitting around evening campfire singing songs.

For the young person with cystic fibrosis, there are day-to-day problems and routines that make living a 'normal' life difficult. But this summer, as for the four summers past, a camp at Lake Couchiching will provide a unique opportunity for adolescents with cystic fibrosis to realize their potential, by learning about their disease, socializing with other young men and women, developing independence from their families, and participating in a recreation program that pushes them to their limits.



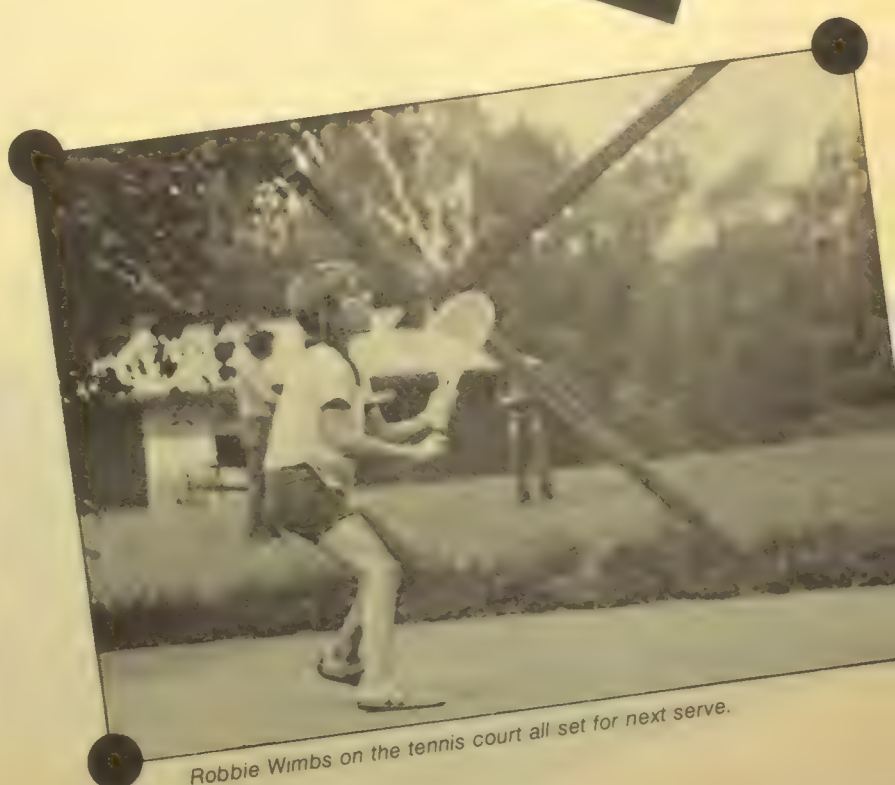


Camper relaxing during inhalation therapy on front porch of his cabin.

Joey Agnello perched precariously over "dunking tank" during Kinsmen Day festivities.



Girls preparing lunch while on canoe trip in Algonquin Park.



Robbie Wimbs on the tennis court all set for next serve.

The nature of the defect causing cystic fibrosis (CF) is unknown. The disease is characterized by an increased sweat electrolyte concentration, pulmonary disease, and pancreatic insufficiency resulting in intestinal malabsorption. Cystic fibrosis is a generalized condition; it affects the entire body, and involves abnormal mucous secretion of the exocrine glands.

The treatment of the disease creates many day-to-day problems for the cystic. The routines required for inhalation and physiotherapy are time-consuming, usually taking a minimum of three hours every day. This makes it necessary for the child to arrange his activities around a demanding schedule.

Many children with CF are self-conscious about their condition, for example, about taking pills in public; many feel guilty about the time and money that their parents spend on them. Some are overprotected by their parents and consequently resented by their siblings. In the past, there have been severe restrictions on their ability to travel, but now the availability of portable equipment makes it a possibility. Until recently, young cystics were refused admission to any 'regular' summer camp; some could attend the camps organized by the Ontario Crippled Children's Society, but their activities there were unnecessarily limited.

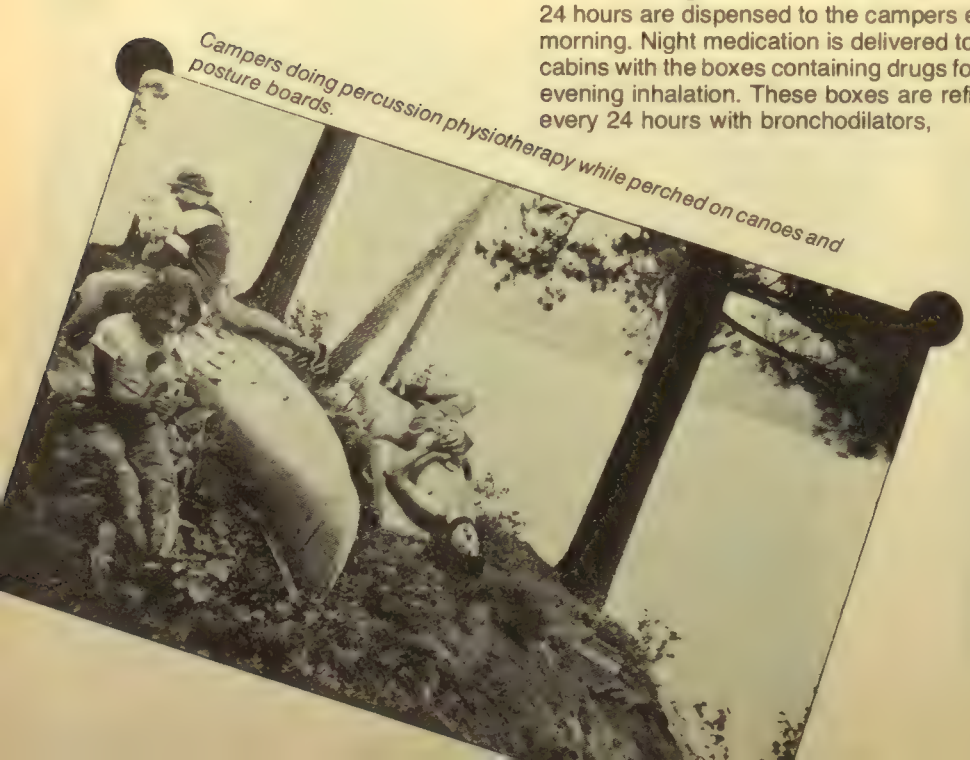
The camp on Lake Couchiching for children with CF was started in 1973 by Dr. Douglas Crozier of the Cystic Fibrosis Clinic, The Hospital for Sick Children, Toronto. Donald Bradbury, past chairman of the board of Camp Couchiching, agreed that for the month of August, the camp was to be set aside for CF campers. A physician (Dr. Crozier), four registered nurses (including myself), a nursing assistant, four registered physiotherapists, and 16 student therapists were hired for the month of August to augment the regular camp staff. By the summer of 1975, the number of campers had grown to 53 (23 boys and 30 girls) between the ages of 10 and 17; 17 staff members, ages 17 to 25 years, also had CF.

Initially, certain changes were necessary to make the camp suitable for CF campers. All cabins were insulated; electric baseboard heaters and hot and cold running water were installed. The veranda of the camp lodge was enlarged and rewired to accommodate postural drainage boards and physiotherapy machines.

The fee for campers is about $600. for the month. Parents are asked to contribute what they can to the cost; the balance is covered by service clubs, especially the Kinsmen Club and local chapters of the CF Foundation, or by donations from drug companies, private individuals, the *Toronto Star* Fresh Air Fund, and other sources.

Most of the activities normally available to campers at Camp Couchiching are continued as usual for our CF campers during the month of August. Swimming lessons are compulsory, and canoeing, tennis, water skiing, hiking, campcraft, arts and crafts, sailing, archery, and overnight trips are offered.

As each camper arrives, he is weighed and his drug records are checked. Each camper brings his own drugs to camp and with a few exceptions, these are pooled and shared. Enough antibiotics and vitamins for 24 hours are dispensed to the campers each morning. Night medication is delivered to the cabins with the boxes containing drugs for the evening inhalation. These boxes are refilled every 24 hours with bronchodilators, antibiotics and Intal in a buffered solution. At treatment time, each camper nebulizes the solution and inhales it for 15 to 30 minutes.



Campers doing percussion physiotherapy while perched on canoes and posture boards.

Good nutrition is an essential part in the care of those with cystic fibrosis. Our camp has an unlimited budget for a diet high in saturated fat and protein; butter is used rather than margarine; whole milk instead of juice; and there is plenty of fresh meat, eggs, and cheese.

The pancreatic enzymes, Cotazymes, called "greenies" by the campers, are distributed at each meal. A counsellor ensures that each camper takes enough enzymes, and notifies a member of the medical team if there is a reluctant pill-taker in the group.

Gentle Teaching ...

Staff members spend a great deal of time teaching the campers about the need for enzymes; that, for example, they need to take eight "greenies" to digest a glass of milk, or 25 for a cup of shelled peanuts. We continually emphasize that for them, food without enzymes is almost like no food at all; explaining to them why they might feel constantly hungry although they are eating large amounts. We try to relate this to their everyday lives suggesting that they should always take "greenies" with them to their local hamburger stand so that a "Big Mac" will have more than just sawdust food value. We also teach them how to take "greenies" inconspicuously, by putting them in a cup and "drinking" them.

I remember one young cystic telling me about the phenomenal amount of food he usually ate, claiming he just didn't need enzymes. After a consultation with Dr. Crozier, I asked the boy to try an experiment, by beginning to take 60 "greenies" with every meal. A few days later he came back to tell me that, for the first time in years, he was not always hungry; generally he felt better, and he began gaining weight.

As staff members, enzymes are far from our only concern. Each cystic child requires two or three physiotherapy treatments every day after the inhalation of prescribed bronchodilators and antibiotics. At camp, each child is responsible for mixing his own mask medication, and, for some, this always comes as something of a shock. We also try to teach the camper how to position himself on a postural drainage board in order to gain the greatest effect from clapping and percussing, and loosen the thick mucus secretions that are a constant cause of concern to him. A physiotherapist, assigned to each cabin, observes the therapy unobtrusively.

Canoe Trip

During the first summer at camp, we included a canoe trip for the older boys. We did two local canoe trips; the boys paddled one way and were trucked back to camp in time for their second inhalation. Our first trip was so bad... The river wasn't deep enough, so the boys had to pull the canoes up the river. Some got lost; three circled an island twice before they realized that they were off course. There

Reactions to Camp

The response of the campers, counsellors and parents to Cystic Fibrosis-Camp Couchiching was measured in part by their replies to questionnaires that we sent to them after our third summer.

All 16 campers who replied to the questionnaire had heard about the camp from their CF clinics; almost all had been to camp for more than one summer. None of the boys said they were homesick, but five girls were initially — they stated that they were not accustomed to being away from home for any length of time.

Only one camper did not take his medication by himself before camp but did so afterwards. The greatest improvement in the campers was in their ability to give themselves physiotherapy; most of the boys could do all clapping positions, including the posterior lobes, by the end of camp; the girls still needed help here. The boys expressed great satisfaction at being able to do their therapy independently, and many felt that they had developed a better routine. Typical of the replies are the following statements:

"I used to do my therapy only where it hurt, and often for a longer time in that area only."

"I realized that I must take better care of myself and not miss any treatments."

"Before, I didn't mind if I missed a mask or didn't take my pills but after camp I tried not to ..."

"While at camp I learned how to take care of myself better."

"Yeah, now I can do all my treatments by myself without having anyone tell me what to do with them."

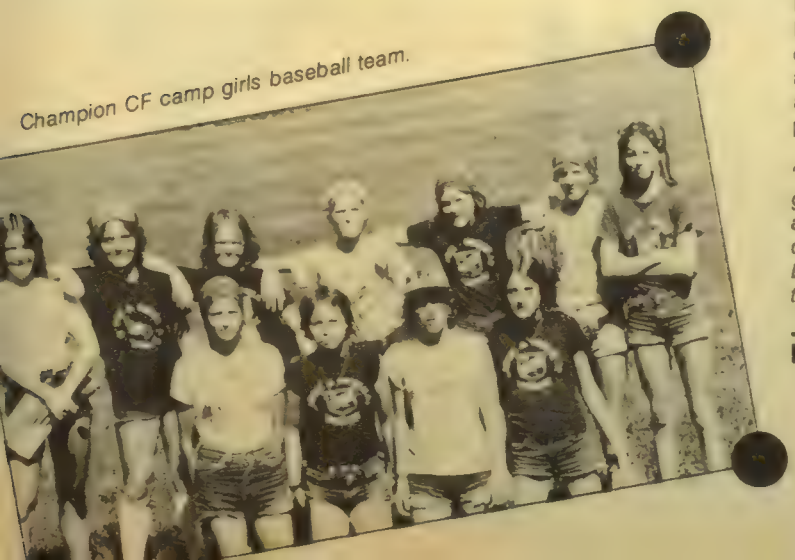
Many cystics feel that they are "different," and are self-conscious about their disease. Many of the campers' responses indicated that they learned to overcome some of these problems at camp.

"I don't get depressed as much after being with kids with CF. I know other kids go through the same things as I do."

"I learned I could do things other kids could do, kids that didn't have CF; before I was in doubt, as everyone was worrying or protecting me."

"Because everybody had CF, I felt that if I coughed or got out of breath, everyone would understand."

"In a way, it made me feel good taking my pills openly and having someone to talk to while doing my therapy."



Champion CF camp girls baseball team.

Most said that they have greater understanding of CF.

"Seeing kids with my disability and talking about our problems improved my knowledge."

"...being with other kids with CF and learning about them, discussing our problems (such as how to take pills in a crowded cafeteria), getting away from home."

"The canoe trip was the highlight of my life. I loved it so much and felt great by being able to participate."

The usual complaints were also voiced: swimming in cold water, food, facilities, the "no phone" rule, and getting up at 8 o'clock in the morning.

The responses of the campers indicated a general feeling of greater maturity, independence, self-confidence, and less social isolation. As for the future, all campers responding said they would like to join the camp staff for all or part of the summer. Beyond that, most were positive about their future, with plans to study electronics, journalism, teaching, nursing, secretarial work, etc.

All parents who returned the questionnaire had heard about the camp through a CF clinic. Their answers closely agreed with those of their children. Three had hesitated sending their child to camp the first year— but none in subsequent years.

Most of the campers had never been away from home before, and their parents worried: others had no hesitation *"...I felt he was becoming too dependent on me (mother)".*

Some parents had trouble adjusting to their child's absence — *"We had a daily routine and while she was away we realized just how much time was spent in treatment." "I missed her and the house was very lonely when she was away."*

After camp, some parents said. *"He did his clapping without so much complaining."*

"He saw others who were in worse shape than he is. He can do anything without problems. He met cystics who were less fortunate."

"She learned how to do her treatments better, and more frequently without being told."

"She seems to understand now that she is not the only one in the world with CF."

Most parents commented that they felt confident in leaving their child with competent personnel for a month, and for many it was their first relaxed holiday in years.

Two of five staff members with CF replied. Both were then spending their third summer at Camp Couchiching, the first two as campers; they felt that being a staff member was much better than being a camper. One stated that he enjoyed the extra privileges accorded the staff, as well as being able to function much easier in this role without being held back. The other said that he seemed to make friends more readily, and was learning how much work is involved in keeping a camp running smoothly.

One staff member had held another job as a mail clerk; the other had never been employed. Neither had been away from home this long before, even for hospital admissions. Neither had had any problems handling the responsibilities of cabin counsellor, in July with the usual campers or in August with the CF campers. Each regarded time at camp as a learning experience. Both thought their own daily treatments were about the same at camp as at home. There was no conflict with the program time but one stated that it cut into his free time considerably.

One of the cystic counsellors stated:

"One month is just right for the CF camp. The kids take about a week to get arranged and feel at ease and anything less would be too short. The activities are quite well liked by the campers. They seem to like the overnights and canoe trips the best since they really seem to conquer being away in the woods and still being able to have their normal treatments."

was fog, followed by a heavy downpour. Only because it was very warm and the biggest and healthiest boys were along did we let them stay out for the night. The boys were not impressed, to say the least, with this kind of camping.

The second summer, the canoeing instructor and I found a route which paralleled Highway 60 in Algonquin Park. With the help of the assistant park superintendent, we worked out the 'connection points' where a truck carrying a nurse and all the inhalation equipment would meet the canoes each night. A physiotherapist travelled with the canoes as part of the group.

The July campers tried out the route for us and came back with glowing reports — enough water in the river, good camp sites, etc. Our next problem lay in convincing our boys that they could do a five-day trip. Generally, they expressed fear of failing; they were afraid that they wouldn't be able to complete the trip, or that they would get sick on the way. One of the main reasons for having a truck and a nurse along was so that if someone did get sick, the trip could continue, and only one person would have to go back to camp.

In order to take part, the boys were required to take campcraft lessons, and had to be able to paddle a certain number of miles, portage canoes several thousand feet, and swim at intermediate level. Physically, they needed to be in good shape for the trip so beforehand they took all their pills, ate well, and (most nights) got enough sleep. But the fear of failure was always on their minds.

We covered every contingency twice with the campers — from heavy rain, to a failure of the power generator, and bears.

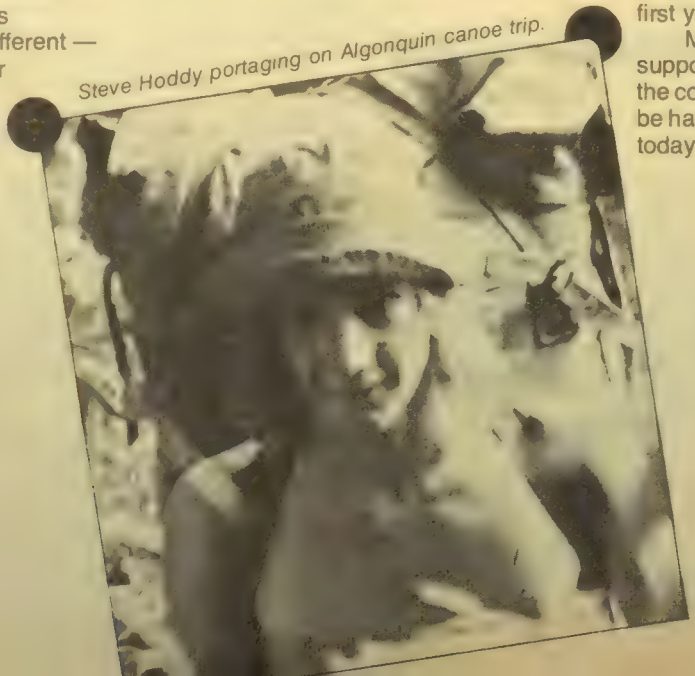
The boys were all very "city," had little bush sense, and would have starved had they ever got lost. For the first three days of the trip, the staff did the cooking, usually while the boys were doing their treatments. On the fourth day, when the campers were required to do the cooking, the fire wasn't lit, the cans of food remained unopened, and they ate peanut butter sandwiches. Several campers wondered why this should be any different — after all, they didn't have to cook for themselves at home, or at camp. Fortunately, this attitude has changed in subsequent years.

The park attendants were a tremendous help to us that year. Our route was known at the summer headquarters, and at each connection point, the park staff, who had been authorized to give any extra help we might need, was notified of our arrival. On one night of our trip, it started to rain heavily, and we had to find a dry area for doing the treatments. The only place available for our use was the park attendant's tiny office. All the boys packed into the office for their treatments and the noise, in such a small enclosure, was deafening. People checking into the park were startled at the sight of kids in masks or percussors, and camp hats, smiling and waving at them. Several asked the park attendants if the boys were divers.

After that evening, we certainly didn't need to introduce ourselves; everyone knew we were in the park. The boys started doing their treatments openly — "Let's go and freak the tourists!"

When the boys landed on the beach at Whitney, the end-point of their trip, they were euphoric, jumping up and down excitedly. They had made it! They hadn't failed, no one was sick, and the weather had been good for the most part. Looking back, they said the trip was "a snap," with a happiness that I had never seen them express. They roared into camp to be congratulated for their fine work. The stories they told were endless, about trying to attract bears into their tents, looking for girls, and on and on ...

As a member of the staff, I found that helping to arrange this trip for the boys gave me a great sense of satisfaction. We had helped in opening a whole new world to boys who had never been away from electricity before, and there was no looking back.



Steve Hoddy portaging on Algonquin canoe trip.

Four Summers

The four summers I spent at Camp Couchiching as a staff member were very satisfying. Our first summer was experimental — just trying to smooth out the drug delivery system and other aspects of having cystics at camp was a challenge.

The second year, we took all the campers to the Canadian National Exhibition in Toronto, a first for many, even for campers from Toronto. The five-day canoe trip was another major event that summer, and it worked out very well. Our baseball team beat every camp in the area. We pushed the campers to their limits, and although there were complaints, they loved it.

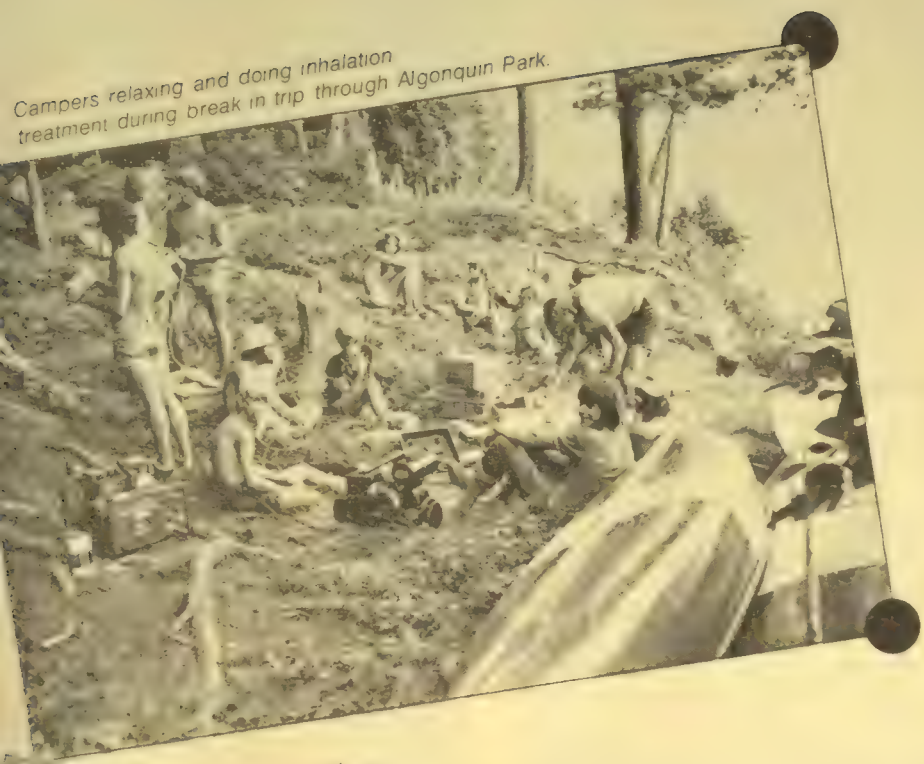
By our third year, some of the girls qualified to go on out-trips in Algonquin Park. By this time, what had been such an anxious ordeal for the campers was simply taken for granted. I could see self-confidence growing with every new skill.

Talking with the campers has led me to believe that they have become more positive in their outlook on life through their experience at camp. In the first summer, I remember one camper asking Dr. Crozier whether he thought it was really worthwhile for him to continue in school, as he wasn't going to live much longer anyway. In contrast, the past summer saw many campers making plans for further education, and many of these plans were put into motion. Now, two of our campers are in nursing, another is at Trent University, another is in electronics, and the list goes on.

Recently, I recall asking our first-year water-skiing instructor, a cystic, how he got to camp. He replied that he was only there to get his mother, sister and Dr. Crozier off his back. By the end of his second week at camp however, he had improved his daily treatment regime; he admitted to feeling better and having a great time to boot.

When I talked to him last summer he said that the CF camp was the greatest thing that had ever happened to him, and that he was grateful that Dr. Crozier had coerced him that first year.

My pleasure came from being a part of the support which gave this young man and others the courage to strive to reach their potential, to be happy, productive, and very much a part of today's society.



Campers relaxing and doing inhalation treatment during break in trip through Algonquin Park.



Julie Trusz (nurse at C.F. clinic H.S.C.) giving Norbert Kratz allergy shots in drug room at camp.



J. Karen Scott, *(R.N. St. Thomas, Ontario; B.Sc.N. University of Windsor, Windsor, Ontario; Nurse Practitioner, University of Toronto, Toronto Ontario) author of "Four Summers ..." has been nurse-in-charge of C.F. Camp Couchiching since its beginning in August, 1973. Her nursing experience includes general duty nursing, camp nursing, V.O.N. experience, a position as a research assistant and psychiatric, surgical, and outpost nursing. Nursing has taken her as far west as Vancouver and to many Ontario communities, including Sioux Lookout. At present, Karen is taking French language retraining for a National Health and Welfare post as Nursing Supervisor at St. Regis Reserve, Cornwall, Ontario.*

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A QUIET DAY...

The old man down the hall is a quiet patient, a 'good' patient in the eyes of those who care for him. Physically, his care certainly isn't demanding and, since his admission, he hasn't called the nurse for any reason. But how does he feel about being here? And what is our role in helping him?

Sharon McKenna

He was an old man. The step that had once measured farm fields and marched through Flanders' mud was slower now and, at times, unsteady. His work-worn fingers picked nervously at the hospital pyjamas that he had put on at the young nurse's instruction. Unsure of what to do next, he sat in the armchair to wait patiently.

He had little experience with hospitals; until now, somehow, illness had never required much more than home remedies. But that time was past. He had slowly let go of his hold on independence, had given in to what he had been told was "for the best." He had come for care.

Everything was neat, tidy and impersonal. No matter who came or went through this room, it seemed that it would remain the same, untouched and anonymous. Shiny panels above the bed attracted the man's attention briefly. Not knowing what they were, he soon lost interest.

The door opened at last. The young nurse entered the room quickly and gathered up the clothes he had left neatly folded on the bed. He would have liked to speak, but he didn't know her name. He had seen a tag of some sort on her uniform and thought it must be her name, but he hated to admit even to himself that with or without his glasses, he just couldn't see very well. And so he remained silent and alone.

The nurse was a first-year student, full of ideas and plans for her life ahead. She had met the old man at the admitting desk and, glancing briefly at his diagnosis and room number, had wheeled him with authority to his new quarters. She had been polite enough. But when she said "How are you?" he had answered according to his perception of what she expected: "Fine, thanks."

The young nurse knew he would be confused in this new environment — there would be so many different faces. Certainly he would never remember her name, even if she had told him. When she took his clothes and said matter-of-factly, "We'll keep these in the private clothes room," he had felt bereft of all identity. Only the band on his arm told who he was.

Again, the door to his room was pushed open. This time, a smiling middle-aged man breezed in. "Hi Pop ... I'm Frank, the 3 to 11 orderly. Everything okay? I need a specimen. If you need anything, just push the buzzer. I'll be back in a while. Don't forget the specimen, eh? The lab closes at four."

A look of incomprehension came over the man's face, but before he could speak, Frank had disappeared. All that was left was a glass jar on the bedside table. The man rose slowly to his feet, and quietly found his way to the bathroom.

When he came back to his room, he saw that someone had been in and turned down the bed. He was tired now, and wearily climbed into bed. His head was too low, so he tried to fold the pillow in half. The plastic cover wouldn't stay folded, so he turned on his sid and dozed.

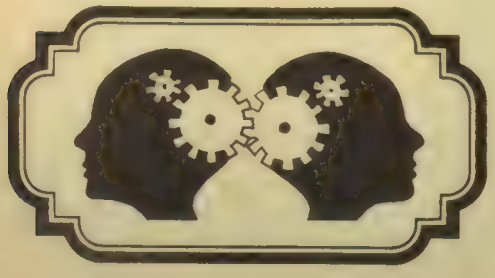
He awakened later with a start to see another new face. For a moment he had trouble remembering where he was, but then all came back. It was dinner time. The old mar thought of being at home in his own kitche He remembered then that this was "for the best."

A little boy came in with the evening new and the old man bought a paper. It was hard t read in the fading light, but he didn't know where the light switch was. He remembere that Frank had said, "Just push the buzzer He wondered where it was.

In the gathering darkness, the old mar slipped into other days, full of sun and laughter, and he smiled as he rememberec And now? Now he was here, quiet and uncomplaining. In time, the staff would grow t appreciate him. He was a 'good' patient an they could chart quite truthfully, 'quiet day'.

But now he wondered who the studen nurse was. Where was the buzzer that Frar had mentioned? And who was the ghost-lik creature who had turned down his bed? H had so many questions, so many fears. He ha been a strong and independent man. Now h had no idea what was in store for him.

When the night nurse brought in his sleeping pills, she pretended not to notice h tear-rimmed eyes. She would help to care f



connection



him, his bed would always be clean, his room dy, and an extra cup of breakfast coffee rdered. But she didn't want to intrude, and esitated to embarrass him by asking him bout his feelings. She smiled gently as she atted his hand. "Don't you worry about nything now. We'll take good care of you, and ou'll see. It's all for the best."

Reaching Out...

Routine care of the old man on the day of is admission and the days that followed did not lace great demands on the ward staff. The eal challenge was one that was never met ecause it was never recognized. None of the eople involved in caring for him recognized hat they were failing to communicate ffectively, that they were frustrating each of is tentative attempts to reach out and touch hem and that he, in turn, was not "hearing" what they thought they were saying. Probably, each member of this staff felt that the care they gave was adequate. They did not recognize their failure to communicate with him in any significant way.

Communication can be defined as "...a sharing of information, signals or messages in the form of ideas and feelings."[1] What messages were the staff members sharing? How did they discourage the old man from expressing himself, and thus leave him deserted and in distress? And how could they have helped him?

The student nurse made an assumption when she saw that the new patient was elderly. Although this assumption led her to conclude that the old man would be confused in his new environment, she did nothing to orient him or alleviate his bewilderment. She made no attempt to confirm her assumptions through conversation with him. And by neglecting to introduce herself to him, she conveyed the impression that he was of little importance as a person in the routine of her hospital duties.

The student's adoption of the 'busy' role can be seen as an attempt on her part to sidestep a situation that somehow seemed threatening to her. It may have served her purpose, but simultaneously it effectively blocked any attempt by the patient to establish contact with her. If she had introduced herself and her unit to the patient, she might have found that her fears were groundless and at the same time diminished the patient's overwhelming sense of isolation.

By showing him how to operate the call bell, overbed light switch etc., she could have made him more comfortable with his surroundings and given him a degree of control. Sometimes showing the patient the view from his window helps him to orient himself physically. Acquainting a patient with his environment requires verbal communication, but there are non-verbal implications as well. They may be that the nurse is open and approachable, that the patient is recognized as an individual, and as such, important and respected.

The orderly was presumptuous in addressing the old man as "Pop." His familiarity may have been offensive or belittling to the patient, a man he had never met before.

Although he told the old man what he had come in for, he didn't give him more than a cursory explanation. His terminology, however familiar to him, was incomprehensible to the patient.

He failed to give the patient an opportunity to become acquainted with him and he failed to confirm that the patient knew what was required of him. His message, "The lab closes at four," had little meaning for the patient, and may have been perceived by the old man as a cause for anxiety. By spending a few minutes with the old man, the orderly might have helped the patient to feel more at home, might have begun an open cooperative relationship with him.

The night nurse preferred to ignore any evidence of the old man's emotional distress, perhaps communicating that his tears were inappropriate or unacceptable. Because she did not encourage him to express his fears, she missed an opportunity to help him to work through his feelings. Her glib reassurance may have helped her to avoid a painful situation. But she could have been prepared to listen, to accept his feelings and encourage him to translate them into words, perhaps alleviating his distress. Such phrases as "You appear...", "I notice that you...", "You seem to be...," often provide the opening that the patient needs to begin a more productive, meaningful communication pattern with a nurse.

All three staff members were basically kind to the old man, but none made an attempt at more than routine care. If any one of them had spent a few minutes to assess and understand the situation that confronted the old man, he might have felt that his life still contained some measure of worth and dignity.

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Sharon McKenna, *author of Quiet Day .... is a first year student at the School of Nursing, Okanagan College, in Kelowna, British Columbia. Her paper was written as a requirement of a course on "Theory and Application of Communication Skill." A graduate psychiatric nurse, the author writes "When I read the qualifications of others whose articles you have accepted, I felt delighted that student nurses are recognized and encouraged to actively participate in the direction nursing is taking today."*

ANOREXIA NERVOSA: A nursing approach

Anorexia nervosa is defined as the condition of "self-inflicted starvation, without recognizable organic disease and in the midst of ample food."[1] The seriousness of the illness is indicated by a mortality rate of approximately fifteen percent.

It is a complex problem and there is some dispute regarding the etiology of the illness. It occurs most frequently in single females in their adolescent or young adult years. Generally, the patients are of average or above average intelligence; often, they have a history of obesity. Although the literature is not unanimous in documenting this, those diagnosed as suffering from anorexia nervosa are described as having been quiet, obedient children, often from financially or socially successful families.

Barbara Butler, Mary Jane Duke, Toni Stovel



Symptoms

Anorexia nervosa is characterized by some or all of the following symptoms:

- amenorrhea
- disturbance in body image and body concept of delusional proportions
- perverse eating habits, including:

1. starvation diets with compulsive overeating
2. gorging followed by self-induced vomiting;
3. hoarding of food;
4. excessive use of laxatives and enemas.

- difficulty in interpreting body cues, such as:

1. inability to recognize hunger;
2. hyperactivity and denial of fatigue;
3. failure of sexual functioning.

- a low basal metabolic rate
- constipation
- a sense of ineffectiveness, that is, a lack of self-awareness. They see themselves as always responding to others' demands rather than to their own desires.

Along with the generally recognized symptoms, we have noted several common behavioral characteristics in patients having anorexia nervosa. One of these is a child-like quality and another is extreme anxiety related to gaining weight. The patient attempts to deal with this great fear of weight gain and to gain control by any means possible, a behavior described as "manipulation."

Manipulation has been defined as a "process by which one individual influences another to function in accord with his needs without regard for the other's needs or goals."[2] It can be seen that manipulation is an interpersonal phenomenon. Within the nurse-patient relationship, the nurse strives to limit manipulative behavior and at the same time assists the patient to learn more mature methods of relating to others in order to satisfy his needs. The use of cooperation, collaboration and compromise are seen as more effective interpersonal methods for need gratification.

Case Study: Margie

Margie, a twenty-one year old, was first diagnosed as having anorexia nervosa in England when she was sixteen years of age. At that time, she discovered that her unmarried sister, two years older, was pregnant. Margie was quite disgusted with the whole matter and was extremely fearful that she, too, might become pregnant. She associated pregnancy with a feeling of fullness in her stomach. It was at this time that she developed irregular menstrual cycles, began dieting, and lost 7.7 kg (17 lbs).

Margie's parents were both successful in their chosen careers. Their marriage, however, had dissolved when Margie was a young girl. Margie had a history of three previous hospital admissions and intermittent psychiatric treatment on an outpatient basis. In addition she had been admitted twice to medical wards for treatment of pneumonia.

More recently, Margie had had one previous admission to our hospital and although she had gained 4.5 kg (10 lbs) her stay was described as unsuccessful. She would sneak food from other patients' trays and hide it in her room under her pillow, between her clothes, and in drawers. This was a constant problem and her room often reeked of stale food. She would harrass the dietary staff for extra food, beg candy from other patients, then gorge herself and induce vomiting several minutes later. Margie was in constant conflict with her need for hunger satisfaction and having to deal with feelings of guilt and fullness. This led to many outbursts and tantrums which proceeded to increase her self-dislike. Eventually it became clear that her stay in hospital was no longer producing worthwhile change, and discharge was recommended.

We readmitted Margie from a medical ward in another hospital where she had been a patient for two-and-one-half weeks for treatment of malnutrition. Her physical status was considered to be precarious; her resistance to infectious diseases was low. In fact during that admission, she had lost another pound so that she now weighed 33.2 kg (73 1/4 lbs) in spite of her height of 170 cm (5'8"). She appeared gaunt and frail. Her sunken eyes and pallor gave her a ghost-like appearance. She was unsteady on her feet and unable to speak more than a few words

Nursing Kardex — Initial Care Plan

Short term goal — Weekly weight gain of 0.91 kg (2 lbs)
Long term goal — Physical stability and health through re-establishing better eating habits.

Problem	Plan
Physical instability	— record intake and output — take vital signs and temperature prior to giving medications — bedrest, in pyjamas — meals in room
Anxiety	— Chlorpromazine 50 mg QID and increased to 175 mg QID — consistent staff visits q 15 minutes — in pyjamas with clothes locked up
Obsession with food and fear of weight gain • hoarding • gorging • vomiting • weight loss • abuse of laxatives	— 0800-0845 breakfast — 1000-1030 snack — 1200-1245 lunch — 1500-1530 snack — 1700-1745 dinner — 2100-2130 snack — consistent staff members to sit with patient during meals and snacks and for one hour following — not to leave room — use call bell if necessary — no conversation during meals and snacks with social conversation following — no psychotherapy — allow patient to eat at own pace but at end of allotted time remove tray from room and calculate numb of calories not eaten (keep caloric values in chart for easy calculation) — equivalent oral Sustagen supplement given with HS snacks a) for total daily calories missed when exceeding 400 calories b) for emesis — supplement per volume — direct conversation away from food — increase roughage in diet — Metamucil 30 cc BID — weigh once a week
Manipulation and resistance to treatment	— weekly contract meetings - Monday a.m. — involve patient in own care plan — be firm and consistent in manner — follow care plan explicitly — patient to have no direct contact with dietician
Dependency • on mother • on material possessions	— mother 1/2 hour visit per day (no other visitors) — one phone call per day — personal articles limited — no further articles brought in unless exchanged for those in present possession
Boredom	— provide limited occupational therapy supplies — provide consistent volunteer member for companionship other than nurses — increase privileges slowly so that we have something to offer patient at each contract meeting.

ANOREXIA NERVOSA: A nursing approach

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a time because of her exhaustion. On closer observation, she showed further signs of malnutrition: anemia, poor skin turgor, little muscle tone and lack of subcutaneous fat.

The nursing staff on the psychiatric unit felt well-prepared for Margie's admission. Articles on anorexia nervosa and manipulation were made available. The dietician, occupational therapist, social worker and psychiatric resident were involved to help establish staff agreement on nursing management and thus consistency in her care. We met to formulate the treatment plan that covered all present and anticipated problems. Explicit and detailed pre-planning left little room for patient manipulation (See Kardex outlining Margie's initial care plan).

Because of Margie's physical instability and previous management difficulties, she was initially put on bedrest in pyjamas; her clothes and possessions were locked up; her visitors and recreational activities were limited. These activities and privileges were slowly increased as her health status improved. It was agreed that the goal of this admission was to attain physical stability and health through the establishment of better eating habits. No attempts were made to explore with Margie the underlying reasons for her behavior through intensive psychotherapy. Those would be achieved later on an outpatient follow-up basis with her psychiatrist.

Weekly contract meetings were established soon after her admission. Each Monday morning, Margie, her primary nurse and the psychiatric resident met to discuss and agree on care plan revisions. Prior to the meeting, the resident and the nurse together reviewed any possible plan changes which were then discussed at the meeting. These meetings succeeded in decreasing staff confusion about Margie's manipulative behavior and also encouraged consistency of care with an open and honest relationship between staff and patient.

We encouraged Margie to become involved in these meetings by allowing her a choice within the boundaries we had set for her. For example, Margie could suggest menu changes or help us decide changes in activity level. We found that when Margie took responsibility for her care plan she was more willing to follow it. This increased her motivation, self-esteem and sense of trust towards staff and, in turn, the staff's anxiety lessened as progress was made. All care plan changes were thoroughly noted in Margie's chart and there were no further changes made until the next meeting.

Margie's conversation centered around food, diets, and her body image. She was constantly worried that she was 'fat': "My stomach is huge, I'm fat;" "Do I look fat?" This misconception of body image was of delusional proportions and was dealt with by redirecting conversation to other areas of interest such as sewing, fashions and poetry. As can be seen by the Kardex, there was constant supervision during and following meals. This was done to prevent hoarding of food and to control vomiting.

We felt the amount of time given to Margie was necessary, at first, due to her lack of physical stability and her unpredictable behavior, sometimes being a charming and sweet girl but just as often a screaming and demanding child. Her manipulative tactics were evident in statements such as "I'm hopeless, I'm ugly and horrible, nobody loves me," or "You're nicer than the other nurses." It was often frustrating for the nursing staff to deal with her constant manipulation and demanding behavior. The amount of time spent with Margie created a feeling of isolation for those working closely with her and was a general energy drain for all staff members. We were fortunate to be able to work through frustrations by sharing our feelings with one another and, of course, a sense of humor helped.

As her physical status stabilized, Margie's activity was slowly increased. From bedrest, she was allowed to sit up in her chair for 30 minutes twice a day, then go for supervised walks in the hallway, then spend a half hour in the patients' lounge and so on. At the same time, she was gradually given back some of her possessions — clothes, jewelry, embroidery, sewing. All these privileges were gained back slowly and only granted at the weekly contract meetings.

Margie's obsession with food never really decreased but she did gain confidence in herself and her diet. As this trust built up, staff slowly decreased time spent with her following meals and finally she was able to eat on her own. Margie was allowed more control over her own care plan changes and although there were occasional setbacks in the form of hiding food from her tray, and vomiting once while on a weekend pass, she managed to control this behavior and it soon disappeared.

On discharge, Margie weighed 40.9 kg (90 lbs) the goal she had set for herself on admission. She was still very thin but she had gained physical stability and was well motivated to continue her diet. It was a fulfilling experience for the staff to observe Margie slowly improve, to gain some independence and begin to establish some healthy relationships. It has been two years since this admission and there have been three admissions since, but each time there is a more healthy response. Margie's weight today is 46.8 kg (103 lbs) she has a part-time job in a daycare center and is beginning to develop a close relationship with a young man.

Conclusion

Patients with anorexia nervosa pose difficult and challenging problems for members of the health care treatment team. For nurses, the behavior patterns of these patients are often a source of frustration, bewilderment and anxiety. The establishment of nurse-patient contracts as a mechanism for limiting the patient's manipulative behavior and at the same time, involving her in the treatment program are seen as effective nursing interventions.

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Beverley McCann, M.Sc.N.

What do a county fair and physical fitness have to do with the public's image of nurses? Taken separately, nothing, but when you put them together, the combination may be just what is needed to create a more enlightened view of the nurse's role as a health educator.

Like nurses everywhere in Canada we had grown weary of our Florence Nightingale image. As members of the Oxford Chapter of the Registered Nurses Association of Ontario, we decided the time had come to do something about changing the public's conception of what we do.

We took Physical Fitness to the COUNTY FAIR



The best way to do this, we concluded, was to find a way to show people we can provide a service which is closely linked with steps they can take to lead healthier lives. With more and more Canadians determined to catch up with that 60-year-old Swede, we hit on the idea of showing how physical fitness benefits health.

A small town tradition — the county fair — presented us with the opportunity to take our message to a good chunk of the population we serve. So, we rented booths at three fairs held in the county and,with some trepidation, prepared ourselves for a brief stint in showbusiness.

We used the allure of a "mini-fitness test" to get people to our booths. We employed such basic testing standards as, weight and height measurement, lung capacity, heart recovery rate and blood pressure assessment, to evaluate the physical fitness levels of participants. (See next page for details)

To personalize our service to the public each person who took the fitness test was closely monitored by one of our volunteers.

We tested more than 1,200 people at the three fairs and answered hundreds of questions on health-related topics.

Did we succeed in making the public more aware of the nurse's role in prornoting good health? Judging by the number of requests we have received to speak to service clubs and to set up other fitness tests, we feel that at the very least, a start has been made in that direction.

Planning Essential

We hope we have convinced other nurses to be more visible in their communities. And for those who are interested in setting up booths at fairs, shopping centers, or other places where crowds gather, our experience may be of some help.

Even though space rented for the booth may be on the small side, every bit of it should be used to promote health themes.

Posters and pamphlets should be imaginatively displayed, and if possible, a "gimmick" should be featured. Ours was a T-shirt which had the words, "I'm a health lover," emblazoned on an oversized heart.

To ensure the display is well-attended, advance publicity is a must. Some of the methods we used included placing posters in public buildings and distributing material to local newspapers and radio stations. All publicity material should clearly identify the local nursing association with the project.

Staffing

In a recent article, Van Der Smissen[1] reminds us there are legal implications in instituting adult fitness programs. In order to protect ourselves and safeguard the public we asked each participant to complete a questionnaire before taking the test (See Fig.1). Thus, anyone known to have heart disease, or who was 69 years of age or more, or had a resting pulse of 100 or greater was advised *not* to attempt the Bicycle Stress Test.

Another way to safeguard the public is to use only active registered nurses who are trained in operating the equipment and prepared to give health instruction if requested.

We needed about 80 nurses to staff the three booths. Each booth was staffed 12 hours a day, and the three fairs ran for a total of 11 days. The volunteers who staffed the booths were employed by the three hospitals in the district, the public health unit and the Victorian Order of Nurses. In addition to general duty nurses, we had nursing administrators, nursing educators and a local industrial nurse helping out. We also had a physical fitness consultant at each fair to answer requests for information on specific exercise programs.

Our planning also included consultation with a medical practitioner responsible for devising fitness programs for cardiac patients. Finally, we wrote letters to the medical chiefs-of-staff at each of the three general hospitals and the chairman of the county medical association, informing them of our project and asking for their suggestions and support.

Figure 1

Physical Activity Readiness Questionnaire (PAR Q)*

For most people, physical activity should not pose any problem or hazard. PAR Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable to them. If you answer YES to any of the questions below, consult with your doctor BEFORE trying the Test.

1. Has your doctor ever said you have heart trouble?

2. Do you frequently have pains in your heart and chest?

3. Do you often feel faint or have spells of severe dizziness?

4. Has a doctor ever said your blood pressure was too high?

5. Has your doctor ever told you that you have a bone or joint problem such as arthritis that has been aggravated by exercise, or might be made worse with exercise?

6. Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to?

7. Are you over 69 and not accustomed to vigorous exercise?

** From the Fit-Kit by the Federal Ministry of Health and Welfare.*

Response

The public's interest in health matters was apparent from the outset. Four newspapers carried stories on our project and two radio stations interviewed nurses staffing the booths. Our Member of Parliament visited the booth and commended us for promoting health. Several physicians and other health professionals were among the thousands of people who stopped to view the display and chat with us.

We were pleasantly surprised by the many children who wanted to know more about proper health care and were keen to see how they rated on the fitness tests. American visitors expressed surprise and appreciation for the free service we provided.

Perhaps the most gratifying response came from nurses themselves. Our early fears about getting volunteers to staff the booths proved groundless as we had no trouble at all in achieving our quota. As a result of their opportunity to work together, public health nurses, staff nurses and nursing administrators improved their rapport and now have a better understanding of each other's role. Following the fairs, questionnaires were sent to each of the 80 nurse volunteers. Nearly all responded and 85 percent felt the project was "very successful" and would volunteer to assist in future endeavors.

The four authors of "We Took Physical Fitness to the County Fair" have caught the fitness bug themselves. They believe if they watch their weight and get a reasonable amount of exercise, other people in the community will realize they practice what they preach.

Kanchan Desai *is the Administrator of Home Care for Oxford County,* **Peggy Hotchkiss** *is the Staff Health Nurse, Tillsonburg District Memorial Hospital,* **Geraldine Fletcher** *is an Area Co-ordinator for Nursing in the Woodstock General Hospital, and* **Bev McCann** *is Co-ordinator for the Diploma Nursing Program, St. Thomas Campus, Fanshawe College*

They were members of a committee established by their local R.N.A.O. to investigate ways to make nursing more visible to the public.

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Photo: Ingersoll Times News

Equipment Used to Measure Fitness Levels

We used standard balanced scales to obtain height and weight measurements. Individual measurements were compared with Metropolitan Life charts.

Posters showing desirable weights for adults and children helped visitors gauge how they "shaped up."

A borrowed vital capacity machine was used to evaluate adult lung function. Located in the center of Canada's tobacco-growing area, Oxford County's percentage of cigarette smokers is probably higher than the national average. Those visiting our booth should have a much better idea now of what smoking does to the lungs. We employed the familiar method of having people take two deep breaths, and on the third one, exhale all the air stored in the lungs into the machine's mouthpiece.

Most authorities agree that the standard exercise bicycle is the best device to determine the heart's recovery rate, the most important indicator of a person's fitness level. We had no difficulty with it, using the following method:
a) Resting pulse was taken before the participant got on the bike;
b) It was taken again after completing a two-minute ride at 25 miles an hour, and thereafter at two-minute intervals.

Blood pressure readings were also taken, and those with high readings were advised to see their doctors.

Clinical Wordsearch

Answers

Puzzle no. 6 (appears on page 38)

1 Freud
2 Group Therapy
3 Glasser
4 Primal
5 Denial
6 Reaction formation
7 Day Care
8 Suicide
9 Valium
10 Alcohol
11 Compensation
12 Neurosis
13 Schizoid
14 Dementia
15 Undo
16 Hypochondriac
17 Jung
18 Pride
19 Projection
20 Self
21 Sublimation
22 Fear
23 Berne
24 Anxiety
25 Deviation
26 Anorexia
27 Ego
28 Emotions
29 Apathy
30 Psychodrama
31 Sociopath
32 Stress
33 Shock
34 Manic
35 Senile
36 Lithium
37 Modify
38 Retarded
39 Phenothiazines
40 Mind
41 Fantasy

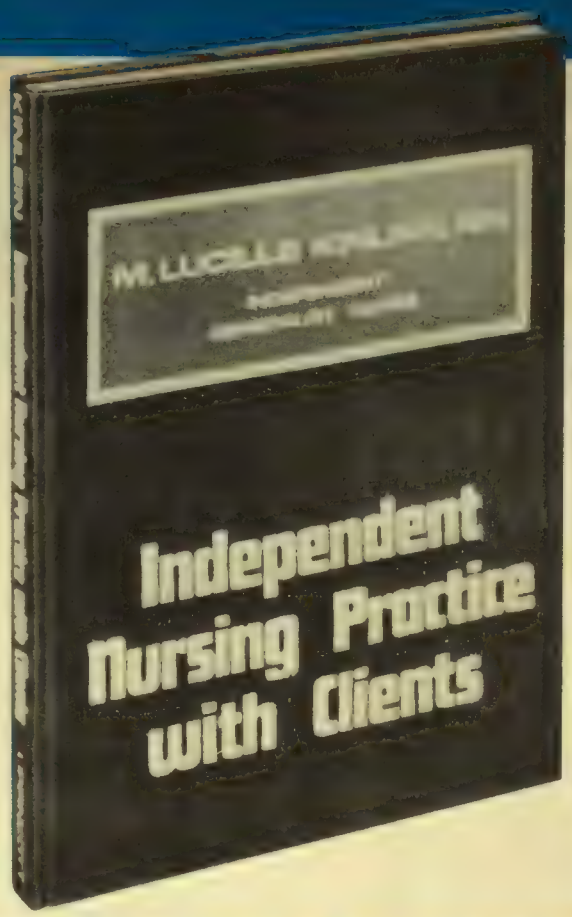
Hidden Answer: Sound body, sound mind.

① INDEPENDENT NURSING PRACTICE WITH CLIENTS

This extraordinary new book is destined to be one of the more talked about contributions to nursing literature. It presents the rationale for independant practice, for giving care, for putting nursing in its proper place in the health field as a practice discipline that is the extension of the client, not an extension of the physician. M. Lucille Kinlein, the first nurse in this country to hang out her shingle, tells how her independent practice came to be; relates her philosophy of independent nursing practice with emphasis on how it differs from the medical model and medical practice; explains how she made aspects of her philosophy operational; and, in an extensive section on *client examples,* spells out the results of nursing judgement and shows nursing measures and their implementation.

M. Lucille Kinlein, *R.N., B.A., M.S.N.E., Independent Generalist Nurse.*

Lippincott 200 pages 1977 $8.25



② ADVANCED CONCEPTS IN CLINICAL NURSING, 2nd Edition

Written by professionals active in their resprective fields, this revised second edition offers valuable guidance to students and practitioners in developing expertise in the more complex and challenging aspects of clinical nursing. It integrates current concepts of nursing assessment and management throughout each chapter. Extensively revised material includes the problems and needs of those undergoing an abortion; genetic counseling and the health requirements of those with hereditary health problems; the immune process and care of the allergic patient; mechanisms of shock; intensive care nursing; and management of the burn patient.

Other new topics include: delivery of health care; psychological concepts of health-related behavior; the diagnostic assessment of health status; and nursing as a primary service in the post-acute phase of illness.

Kay Corman Kintzel, *R.N., M.S.N., Editor; formerly Instructor in Research in Nursing Graduate Division, University of Pennsylvania. With 29 contributors.*

Lippincott 784 pages 137 illustrations 1977 about $21.00

New books and

③ ILLUSTRATED GUIDE TO ORTHOPEDIC NURSING

With over 500 figures and photographs, this lavishly illustrated manual covers the *major problems* encountered by nurses in the orthopedic unit. Emphasis is on nursing *care* of patients in casts or traction, those undergoing hip repair or replacement, knee repair or reconstruction, spinal surgery, amputation, or common shoulder, foot, or hand surgery. Basic anatomy is described, along with surgical procedures.

Numerous figures and photos illustrate the various aspects of anatomy, surgery, and nursing care. Each of the figures is carefully correlated with the text material so that discussion and figures will flow in meaningful sequence. An appendix at the end of the text presents a summary view of classic fractures and their treatment.

Jane Farrell, *R.N., Orthopedic Clinician, Assistant Nursing Instructor, School of Nursing, Bellin Memorial Hospital, Green Bay, Wisconsin.*

Lippincott 242 pages 550 illustrations 1977 paperbound $10.95

④ DISTRIBUTIVE NUSING PRACTICE: A Systems Approach to Community Health

Based on a belief that most diseases stem from the ways people live, this challenging book focuses on *preventive health care* based on education and preventive treatment of populations "at risk" because of environment, employment, heredity, and adverse health practices. Specifically it assists practitioners to 1) utilize a systems perspective for nursing intervention; 2) employ nursing practice components independently and collaboratively to promote, maintain, and restore health, prevent illness and facilitate health-abetting behavior; and 3) develop professional roles for delivery of optimal health services.

Joanne E. Hall, *R.N., M.S., Associate Professor School of Nursing, Duke University, Durhan, N.C.; and* **Barbara R. Weaver,** *R.N., M.S., Associate Professor, School of Nursing, Capital University, Columbus, Ohio.*

Lippincott 530 pages 1977 $15.25

⑤ PAIN: A Sourcebook for Nurses and Other Professionals

A landmark study of a topic of immediate concern to all nurses. The authors present the most up-to-date information available on all aspects of pain, its assessment and alleviation, as well as specific clinical applications based on the theories and research of the more than 30 contributing authors. They also demonstrate how the great promise of major research projects undertaken by nurses can be fulfilled and translated directly into practical improvements in nursing care.

Edited by **Ada Jacox,** *R.N., Ph.D., University of Colorado.*

Little, Brown about 500 pages illustrated 1977 about $16.00

6 ORTHOPEDIC NURSING

A lavishly illustrated, comprehensive text on the most widely approved techniques and procedures in orthopedic nursing. Written by two top authorities in the field, this book covers such topics as nursing assessment of orthopedic patients (following the Standards for Nursing Practice), pertinent laboratory studies, application of the cast and cast revoval, and x-ray interpretation. Of special interest are chapters on mechanism of injury and diagnosis of trauma, common disease processes related to orthopedic problems, and orthopedic complications.

Clara A. Donahoo, *R.N., and* **Joseph H. Dimon, III,** *M.D., both at the Peachtree Orthopedic Clinic, Atlanta.*

Little, Brown **260 pages** **illustrated** **1977** **$13.75**

7 NURSING CARE OF THE GROWING FAMILY: A Child Health Text

A major new student text in pediatric nursing that comprehensively covers family-centered child health care with extensive attention to normal growth and development and emotional and social dimensions of the family. This second of two volumes discusses thoroughly the latest nursing techniques and procedures and emphasizes the broader role for nurses in today's health care system. Topics covered include the growth and development of the child at all ages, newborn through adolescent, health assessment of children, and nursing intervention with the ill child.

Adele Pillitteri, *R.N., B.S.N., M.S.N., P.N.A., State University of New York at Buffalo.*

Little, Brown **834 pages** **illustrated** **1977** **$19.75**

editions for 1977

8 THE CLINICAL PRACTICE OF MEDICAL-SURGICAL NURSING

A major new classroom text that focuses on patient care experiences, this highly readable book incorporates all the scientific background necessary for a full understanding of nursing responsibilities. The authors integrate the physical, psychological, social, and technological components of nursing into the clinical nursing procedures. Each chapter includes the full spectrum of nursing care, assessment, primary care, acute care, chronic care, and rehabilitation. Extensively illustrated with line drawings, photographs, diagrams, and color illustrations, this book provides students with a comprehensive picture of this most essential nursing field

By **Marjorie Beyers,** *R.N., M.S.N., Evanston Hospital, and* **Susan Dudas,** *R.N., M.S.N., Department of Health Education, and Welfare, and the United States Public Health Service.*

Little, Brown **1236 pages** **illustrated** **1977**
paper, $19.75 **cloth, $27.00**

9 THE CHILDBEARING FAMILY: A Nursing Perspective

The well-organized and easy-to-follow chapters of this important new text focus on the biological changes in the expectant mother as well as on the emotional needs of the mother and father. A unique feature of this major book is its cogent discussion of such current issues in maternity nursing as psychological adjustment to pregnancy, the unwed mother, the unwed father, single parents, and the father's role in pregnancy and childbirth. Also included are chapters on sexuality and the structure and function of reproductive organs and on pediatric conditions encountered in obstetrical nursing.

Mary Ann Miller, *M.S.N., University of Pennsylvania School of Nursing, and* **D. Brooten,** *M.S.N., College of Allied Health Sciences, Thomas Jefferson University.*

Little, Brown **500 pages** **illustrated** **1977** **$16.50**

10 THE PSYCHOLOGICAL AND SOCIAL IMPACT OF PHYSICAL DISABILITY

This is a primary text for training rehabilitation counselors and an up-to-date resource for practitioners. Readings in areas like interpersonal relations, sexuality, and consumerism document advances in this country in helping the disabled with respect to their multifaceted needs. Included is a review of rehabilitative steps, among them the new Structured Experiential Therapy.

Edited by **Robert P. Marinelli,** *and* **Arthur E. Dell Orto.**

Springer **414 Pages** **1977** **$19.75**

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NURSING THE ALCOHOLIC PATIENT

Alcoholism and drug abuse now rate as Canada's third most serious health problem but controversy and uncertainty still surround treatment techniques for the individual who is addicted to alcohol. The author suggests that nurses can help the alcoholic take positive steps towards responsibility for his total problems by restructuring existing programs to take advantage of community resources.

Arlee McGee

Many, if not most, doctors and nurses are poorly informed and lack understanding of the various manifestations of the problems of the alcoholic. Schools of medicine and nursing virtually ignore it in their curriculum planning.[1] Some nurses are further handicapped in their dealings with these patients by feelings of inadequacy, the notion that they are dealing with a "hopeless case," that nothing constructive can be done to help the alcoholic, or an inherent disapproval of alcohol use. [2] Knowing all this, I decided while I was an RN student in a bachelor's program in nursing that this was the public health problem that concerned me most. I began then to acquire data on all facets of this addictive disturbance and, when the time came, elected to do public health field work in the area of alcoholism.

As a preliminary step, I became involved in an independent treatment center (government financed, but governed by a board of directors). Because of my nursing experience I was given a great deal of leeway by both the nursing faculty and the board. I reviewed a proliferation of books, pamphlets and documents related to alcoholism; chose courses to supplement my reading, (e.g. Counselling, Deviance, Small Groups, Reality Therapy, etc.); researched and prepared a number of papers on various aspects of alcoholism; visited Alcoholics Anonymous and Al-Anon groups. (I was previously fortified with a psychiatric nursing and public health background). Even so, when faced with first-hand experience, I was not really prepared for the actuality and extent of the problem.

Alcoholism is a problem area which seems to have no universally accepted definition. One author describes it as "basically a means of avoiding the responsibility of life situations."[3] Looked at in this light, alcoholism becomes a symptom of a problem, rather than simply a problem.

There are many theories about the causes of this phenomenon. Research into the three dimensions — physiological, psychological and sociological — has resulted in some understanding. For example:

Physiological Factors *— Neither chemicals in specific beverages nor physiological, nutritional, metabolic or genetic defects have been found which can explain alcoholic drinking.*

Psychological Factors *— If there is such a thing as an alcoholic personality, its specifications are poorly defined, often contradictory and seem to apply to all mental illness.*

Sociological Factors *— Research shows that alcoholism is widespread in some national, religious and cultural groups. It is rare in other groups, for example Mormons and Jews. The lowest incidence of alcoholism is associated with certain habits and attitudes.*[4]

Methods of treatment are as diverse as the suggested causes of alcoholism. Basically there are two distinct approaches, a conventional method and one that utilizes techniques based on the learning theory.

Conventional treatment involves individual counselling, group therapy (including AA), and the use of vitamins, tranquilizers, antidepressants or Antabuse. Learning theory techniques may involve aversion conditioning which incorporates the use of means of making alcohol a negative rather than a positive stimulus. A newer approach aims at teaching the patient through behavior modification, to become a social drinker.

Alcoholism is commonly thought of as a chronic disease but E.J. Larkin, Psychologist Operations Research, Addiction Foundation of Ontario, points out that by accepting alcoholism as a chronic disease, we also accept the concept of uncontrollable drinking. We imply that an individual is not responsible for his behavior. He suggests, on the other hand, that the alcoholic *is* responsible for the behavior which occurs when he has been drinking and must take responsibility.[5]

Acute treatment for alcoholics involves a detoxification period (five to seven days), sometimes followed by short-term rehabilitation (28 days). In many areas a non-medical approach is stressed. Nurses will recognize the value of a non-medical approach which de-emphasizes use of tranquilizing drugs (alcoholics can become cross addicted when tranquilizers are substituted for alcohol). However, when this non-medical approach also involves lack of physical examination within the first 24 hours of detox, undetected secondary problems (physical, mental, social), ignorance of nutritional needs and a general lack of other guidelines to promote a change in total lifestyle then there is cause for concern. If an alcoholic is simply taken in for care and sheltered until his body is physiologically "dried out," major health problems can be overlooked and a revolving door syndrome encouraged. Medical intervention is essential at this critical stage of treatment.

Learning and unlearning

What I saw when I looked at the center where I worked was a non-medically oriented program that did not encourage the alcoholic to attempt to find long-term solutions to his total problem. I was convinced that what was needed was a "now and tomorrow" community approach.

The first step was an assessment of the needs in the existing treatment program. This was accomplished through visits to the center, interviews with members of the board, staff, patients and community resource persons.



Priority was given to the area of staff education. (The staff consisted of eleven male alcoholics and two female non-alcoholics whose previous training was on-the-job, and whose educational backgrounds were varied but limited). The course that I designed was intended to meet their specific needs and, indirectly, the more basic immediate needs of the patients. (The center accommodates two females and eleven males for detoxification and short-term rehabilitation; most patients are of mid- to lower-socioeconomic status).

I was aware that, as a nurse, I was susceptible to the biases against the alcoholic client that are described in the literature. This helped me determine how I should present myself to the clients and staff and to experience a kind of 'anticipatory socialization.' Research also convinced me that I should strive to be non-judgmental and to react on a non-threatening level as an equal. A teacher-helper role seemed most appropriate.

A teacher sets goals. The specific long-term goal for my program was to present a number of instructional classes for health workers of an alcoholic detox center. A broader short-term goal was to identify needs of workers and clients and to seek appropriate solutions.

Many theorists suggest that alcoholic behavior is learned and, in view of this fact, a goal-oriented approach seemed more suitable than a problem-solving one. The staff for example, were notified that on completion of the course, a certificate and possible salary increment would be awarded. A course was designed to entail 30 hours of classes. Plans for the staff included new learning, unlearning and relearning — in essence it meant change. "People are likely to accept a proposed change when it makes demands whose components they have already learned or feel confident they can learn.[6] Classes were designed and presented in the light of this knowledge of the change process. Specific lessons included:

1. A general outline of criteria for care given in some other Canadian detox centers, accompanied by a film on detox programs.
2. Acute care of a patient in detox with emphasis on delirium tremens and care during convulsions.
3. Instruction and demonstrations on cardiopulmonary resuscitation.
4. Continuation of recognition of vital signs, TPR Measurement, secondary problems.
5. General nutrition of the alcoholic (including detox period).
6. Suicide, including drug abuse.
7. Safety, basic first aid, moving of patients and demonstration of lifts.
8. General physical care, secondary effects of alcohol (cirrhosis, etc.)
9. Listening skills, interviewing and recording.
10. Rehabilitation and introduction to reality therapy.

Many resource persons were utilized in this teaching program, including a nutritionist, physician, St. John Ambulance persons and counsellors for role playing. A ' graduation' was held and an evaluation of the program indicated that the long-term goal was reached satisfactorily.

On the completion of this instructional program, the board requested that I return to the center as Co-ordinator of Patient Care and Service. In that role, I have designed a second program with a specific treatment approach. The opportunities to utilize nursing skills have become more numerous and challenging.

Working in a treatment center for alcoholics provides a nurse with one of the most challenging experiences of her career. The problems that she encounters are unique and demand all of her nursing skills. These problems are apt to fall into three categories:

- community support
- administration
- client characteristics

Trial and error suggests that the following approaches may be helpful to nurses working in these settings.

I Community support

Barrier: Community attitudes, unconcern and/or unawareness of alcoholism in immediate area.
Useful Approach: Talked with groups of women, professionals and friends and invited them to the center. Involved the clergy in weekly visits. Informed the Chief of Police and civic officials of the center's work. Included a description of the program in all correspondence. Positive publicity is important.

Barrier: Community resource persons not coming to the alcoholic center.
Useful Approach: Took the center's staff to the community resources, i.e. the university, hospital emergency and psychiatric units etc. Conducted meetings for staff at the university with a pharamacist, physician and counsellor. Invited R.C.M.P. and mental health officials, etc. to the center for presentations.

Barrier: A patchwork quilt of support systems operating independently in the community.
Useful Approach: Shared patient information frequently with other disciplines. Worked through public health nurses and phoned agencies regularly to update client data. Being a member of an agency board is useful for keeping one's self informed. (e.g. Mental Health Local Branch)

Barrier: Medical community superficially involved in care of the alcoholic patient.
Useful Approach: Made frequent referrals to physicians for physical care of patients. Designed a Medical Treatment Record card for patients to take to the hospital and to the doctor's office. The card includes patient information for doctor's use and a record of his assessment and recommendations. Involved the Medical Health Officer re chest x-rays of staff and patients. Corresponded with Medical Society re drug control (doctors prescribing too many tranquilizers for patients). Independent meetings were held with physicians to request routine medical care for alcoholics in the area.

II Administration

Barrier: Some non-medical people involved with government alcoholism programs regard medical persons as a threat to their established treatment methods.
Useful Approach: Nurses must keep well informed, practice patience, tolerance and speak firmly on issues which are their concerns. Positive program results will eventually help gain the support of "doubting Thomases."

Barrier: Working with clients allows limited time for in-service.
Useful Approach: The Faculty of Nursing of the University of New Brunswick allowed three senior nursing students to do public health field work at our center. They acted as resource persons for in-service. A retired psychiatric nurse (former superintendent of a Canadian hospital) also helped on a voluntary basis.

Barrier: Staff members at times not 'weller' than patients.
Useful Approach: Held discussions on lifestyle using material from Health and Welfare Canada. Enforced a decrease in smoking during group meetings. Changed coffee at the center to decaffeinated. Gave staff Vitamins B and C (same as patients receive). Encouraged staff to relate problems in group sessions. Used bulletin board for educational material relating to lifestyle.

Barrier: Staff discouragement with repeaters and chronic inebriates.
Useful Approach: We try to look at old problems in a new way. One patient from our center has been accepted into a Senior Citizens' home and is maintaining sobriety. One chronic inebriate is awaiting plastic surgery for a body image problem. We try to utilize patient skills in our program, i.e. paperhanger, projectionist, cookee, etc. We work with employers on short-term employment arrangements. We have access to facilities at a Community Service Center co-ordinated by a psychiatric nurse for day-to-day recreation.

Barrier: Kitchen staff not sufficiently informed about specific dietary needs of alcoholics, resulting in nutritional deficits.
Useful Approach: A provincial nutritionist completed a food consultation upon request. Two home economics students have consented to do independent studies at our center and at the same time assist the cook with menus, ětc. A useful reference is "Guidelines for Nutrition Care of Alcoholics."[10]

Barrier: Nurses have been conditioned to believe what the patient offers verbally.
Useful Approach: The term "con-artist" is synonomous with alcoholic. Confrontations are a frequent part of communication. After a series of confrontations, a working relationship can be established.

III Client characteristics

Barrier: Alcoholics have the attitude that only an alcoholic knows about alcoholism.
Useful Approach: Designed and administered questionnaires on various aspects of alcoholism (together we are becoming conscious of our lack of knowledge).

Barrier: Difficult to determine a specific treatment approach when planning a program for alcoholics.
Useful Approach: We chose a multi-moderate approach. Included AA, individual counselling and group meetings. Vitamins are given and tranquilizers de-emphasized. William Glasser's counselling theory is a practical guide. He advocates the teaching of responsibility as the main emphasis in psychotherapy.[8] A guideline used by the Johnson Institute of Minnesota is helpful for group work.[9]

Barrier: Short stays and transient nature of clients create problems in attempts to rehabilitate and resocialize alcoholics.
Useful Approach: Alcoholism is a negative concept. At our center we attempt a positive feedback system. We discourage toxic behavior and encourage nourishing actions. We hold insight groups, not group therapy sessions. We include talks on positive commitments of patients and positive characteristics of self, etc. Meaningful relationships are still hard to develop over the short run. We use appointment cards for follow-up visits to help prolong treatment. We refer selected candidates to long-term rehabilitation programs elsewhere.

Barrier: Difficulty getting female alcoholics to overcome stigma attached to accepting treatment.
Useful Approach: Public Health Nurses can be good sources for identification and referral of female alcoholics. We also get referrals through a crisis center and local women's group. Obtaining female patients remains a problematic area.



Arlee McGee, *author of "Nursing the alcoholic patient," recently completed her post basic nursing degree at the University of New Brunswick School of Nursing in Fredericton. She is a graduate of Victoria Public Hospital School of Nursing in Fredericton and received a diploma in psychiatric nursing from the University of Western Ontario in London.*

Of her work with alcoholics she says, "there are many other aspects I would like to have described, such as sharing recipes with the cook, shopping for wallpaper with clients and handing out fried chicken at the Christmas party." She comments also that "We function with extreme flexibility; counselling is done at the kitchen table, my five-by-five office and in one of the bedrooms. However, elegant surroundings are not essential to giving good care in a detox center."

The nurse in the detox center

A nurse who works in a detox and short-term rehabilitation unit undertakes many tasks that are not usually considered her exclusive function. One of the key reasons is that the opportunities for her to utilize various nursing skills are endless. The following description of the clientele illustrates some of the reasons for this:

"The physical health of the heavy alcohol user is typically poorer than that of the general population. Some illnesses result from the direct effects of alcohol, or they may involve other factors such as general lifestyle, nutritional deficiencies, heavy use of other drugs (i.e. tobacco, tranquilizers, aspirin), bodily injury due to accident and other violent mishaps, inadequate hygiene and rest; over-exposure, over-crowding and other forms of stress."[7]

Added to this, heavy alcohol consumption involves a variety of psychiatric and neurological disorders. Social problems, inconsistent relationship to crime and family crises are overwhelming.

On a formal level therefore, my nursing role in the center includes performance as:

Counsellor — to workers, clients and family members.

Protector — *prevention was necessary in many aspects, including drug control and attempts to alleviate secondary effects of alcohol. Follow-up was an important aspect.*

Collaborator — *this became a key issue as negotiations with outside agencies and the center's board were frequent. Collaboration was done with doctors on patient's behalf.*

Advocate — *continuous recommendations were made to the various bureaucracies for improvements in the alcoholic treatment program.*

Teacher — *the main thrust was in the in-service education program.*

Comforter — *comforting care was provided to clients when situations presented themselves.*

A nurse functioning in detox must be well informed on signs and symptoms of patients in withdrawal, delirium tremens and dry-drunk symptoms. She should have information on Antabuse, Temposil and mood-altering drugs. She requires knowledge of the functions of Alcoholics Anonymous, other treatment centers, government policies on alcoholism and the peculiarities of the alcoholic subculture.

A physically unwell, emotionally confused and socially maladjusted alcoholic comes to a treatment unit to dry out his body physiologically. Under the present system, he is then discharged from some detox and short-term rehabilitation programs — a sober, physically unwell, emotionally confused and socially maladjusted alcoholic.

Stepping stones to the community should be laid while he is undergoing treatment so he can take positive steps toward responsibility for his total problems. Alcoholism need not be a dilemma when an alcoholic is viewed as a total person with other problems besides alcoholism. Present programs can be improved at relatively little cost by utilizing community resources. Nurses possess the versatility to put such programs into effect.

In summary, nursing in alcoholism is probably the most stimulating area in the profession. There seems to be nothing the nurse in this field doesn't do — negotiate with bureaucracies, administer physical care and participate in psychiatric and public health nursing. What more could any risk-taking nurse ask for?

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In the early 1820's, a Scottish doctor, Thomas Lotta, administered the first intravenous infusion to patients suffering from cholera. Since then, we've gone a long way in improving the technique. Nevertheless, hazards still exist for all patients on I.V. therapy. This "idea exchange" discusses one such hazard — foreign particles in I.V. fluids — and gives some tips on how you can be alerted to their presence in the intravenous fluids you administer.

Idea Exchange

A hazard of intravenous therapy — CORED PARTICLES

Michel C. Bessette

The parenteral route is the most controlled and expedient method of fluid administration, and in many cases, is a life-saving measure. It is also, however, the most dangerous method of administering fluids and gives rise to potential complications. Many of the hazards such as thrombophlebitis, pyogenic reactions, air emboli and circulatory overload are generally known and are closely monitored. One hazard that may not be as well known but which is potentially harmful is the presence of foreign particles in large volume containers of parenteral fluids.[1,2] The effect that these particles have on the patient receiving intravenous fluids is fortunately avoidable.

The removal of particles smaller than 50 millimicrons in diameter, which cannot be detected by visual inspection at the time of administration, can be achieved by the use of intravenous sets equipped with a filter. Larger particles can be prevented from entering the patient by adherence to proper technique, and by visually inspecting the administration set prior to starting the infusion.

Recently, at this hospital, a number of intravenous sets have been found to contain these larger particles. (Figures 1 and 2) These particles, although readily visible, can easily pass into the patient's vascular bed through a large gauge cannula. (Figure 3) The particle in these photographs is a piece of the "rubber"[3] stopper which was cored, and introduced into the fluid path at the time that the stopper was pierced. A 16-gauge central venous catheter was connected to the set at the time the particle was discovered.

If it entered the patient, this particle would have passed through the right atrium and ventricle and lodged in a lobar or segmental artery. The resulting interruption of circulation may have caused a pulmonary infarction.[4]

The use of a filter will prevent the introduction of particles. The disadvantages of filters are the increased cost and the inability to utilize them with some fluids, for example crystaloids.[1,5]



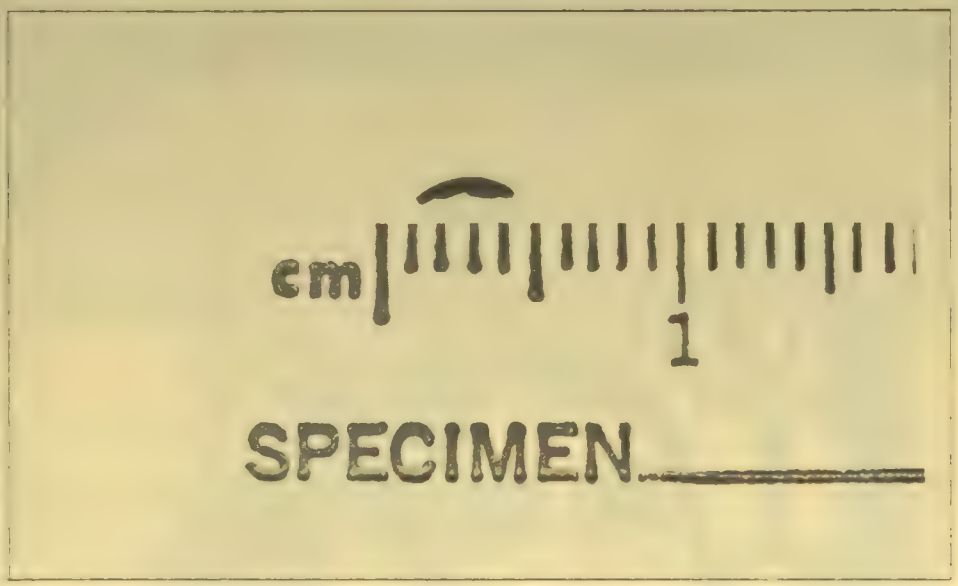


Figure 1 — *Photograph showing the size of the particle described in this article.*

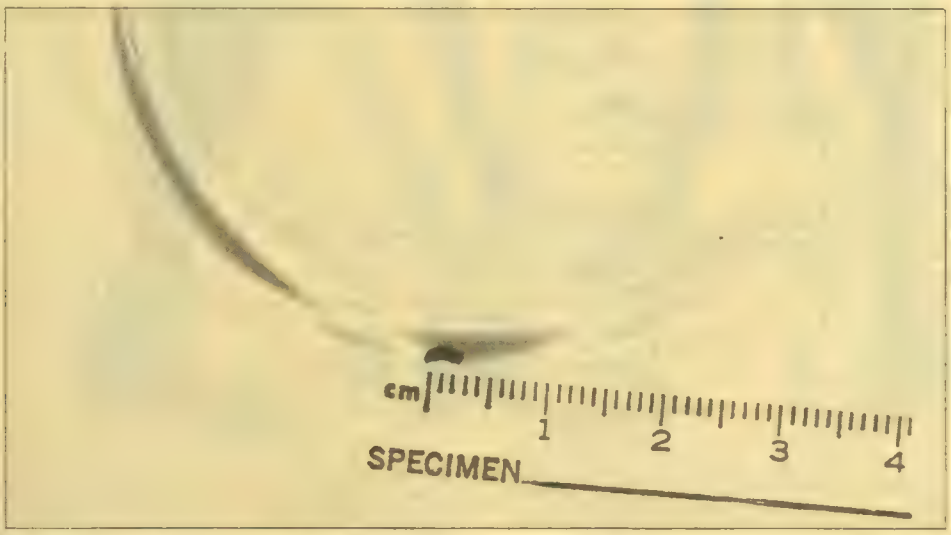


Figure 2 — *The particle inside the tubing of the intravenous set.*

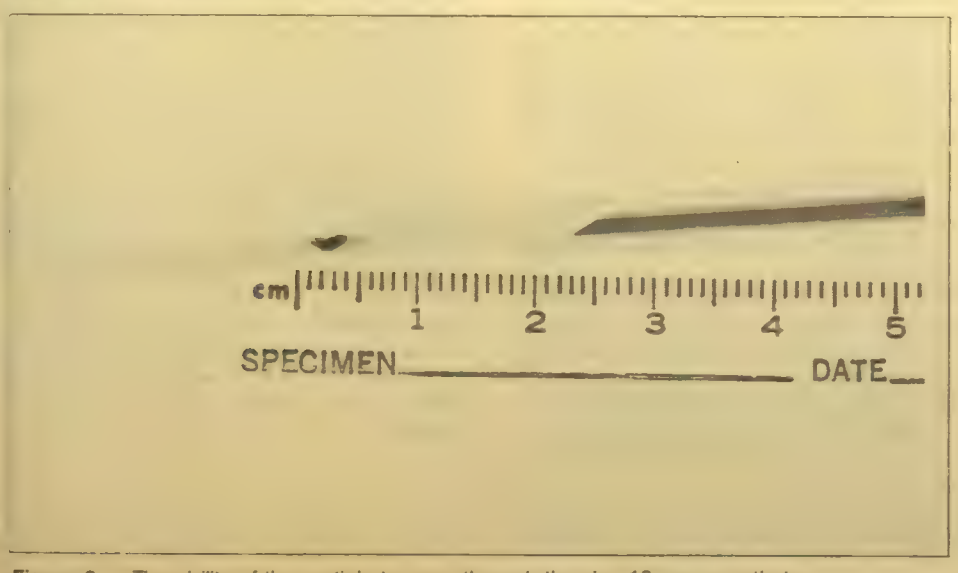


Figure 3 — *The ability of the particle to pass through the size 16 gauge catheter.*

Guidelines

When using intravenous sets which do not have a filter, the following guidelines may be of help in avoiding the introduction of visible particles.

- Push the piercing pin straight through the center of the stopper. Do not twist or angle.
- Visually check the contents of the container for particles. Ideally the container should be held against both a white and black background to detect both black and white particles, respectively.[6] Look at the interior surface of the stopper for particles which may become dislodged with movement.
- Purge the air from the I.V. tubing. Once the air has been removed, inspect the entire set, including the container.
- Never connect a cannula to the intravenous set before ensuring that the fluid path and container are free of particles. This is of utmost importance since a particle will be difficult, or impossible to see if it has passed into the cannula or needle.

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Presently employed at the Queen Mary Veterans Hospital as the Department Head of Inhalation Therapy Anesthesia Technology, Michel Bessette graduated from the Toronto Institute of Medical Technology in 1972 with a diploma in Respiratory Technology. He received certification from the Canadian Society of Respiratory Technologists in 1973. He is presently the Vice-President of the Quebec Corporation of Inhalation Therapy. He was previously employed at Vanier College as a clinical and classroom instructor in Inhalation Therapy Anesthesia Technology.

Acknowledgments: *The author wishes to thank the nursing staff of the Surgical Intensive Care Unit, and V. Frechette of the photography department of the Queen Mary Veterans Hospital.*

Care vs. Custodialism



Following publication of ***"Nursing the Acutely Psychotic Patient"*** *in February, CNJ received a letter from* ***Jose de Cangas,*** *on behalf of the Faculty of the school of nursing of Brandon Mental Health Centre in Brandon, Manitoba. The letter raised these points:*

..."the impression one gets is that whenever a nurse is faced with an acutely psychotic patient, she should call in the marines and administer enough medication to accomplish a state of complete submission. Although this approach may be resorted to in extreme cases, it should by no means constitute the general rule. If such an approach were condoned by health care givers, then I am afraid that the head nurse in the now famous "One Flew Over the Cuckoo's Nest" would also be seen as someone to be idealized. As most readers will recall, she also strived for control as her number one priority.

1. The author uses the word *control* ten times explicitly, and alludes to mechanisms of behavior control throughout the article. Psychiatric nursing does not have as its prime objective *control* but rather, *care.*

It is a mistake for nurses to think that the *most important* thing is to show that they have control. The emphasis is not on control with such clients, rather the client being reassured and assisted to regain control of his/her environment and behavior.

2. Why so much concern about hostility? Most psychotic patients are not hostile even in the acute episodes.

3. One cannot make sweeping generalizations about the nursing care of this type of client because its application in toto, often leads to anxiety responses in the client and thus, hostility. What the author does not seem to understand is that such an anxiety-hostility paradigm is the direct result of unskilled nursing intervention.

4. Even the most "psychotic" clients have lucid intervals. Naturally the nurse can use them *only* if she/he is able to recognize them.

5. The importance of behavioral analysis, nursing and social histories are not even mentioned in this article. This data gathering is essential in caring for these clients as, through them, factors are identified, which not only point out the behaviors leading to violent outbursts, but also enable us to avoid them.

6. Mattresses on the floor! Maybe padded cells next and chains following? This is seldom necessary. As a matter of fact, it accounts for more anxiety building in both staff and clients.

7. Isolation — we cannot generalize as most commonly this leads to further depression and withdrawal.

8. Medications — they are an adjunct to therapy. They give symptomatic relief, but *are not* the only means of helping the client. Certainly not an end in itself, as seems to be implied.

Author Janet Berezowsky responds to these concerns:

I appreciate your extreme discomfort with my use of the word "control." I also acknowledge your concern about the whole issue of control in nurse-patient situations. It has been my experience that nurses are often not comfortable with such an open and direct description of nursing intervention. It has also been my experience that such anxieties are expressed primarily in reference to psychiatric patients. However, I do not discriminate between the appropriateness of the nurse taking control in any of the following situations:
— limiting the privileges of the suicidal patient,
— providing skin care for the immobilized patient,
— forcing fluids on the dehydrated patient,
— administering CPR to the patient in cardiac arrest, or
— medicating the acutely psychotic patient.

In each case the nurse acts on the basis of her assessment of the patient's needs as expressed through his behavior. To fail to take control in these or numerous other situations constitutes negligence.

Nurses frequently fail to realize that nursing intervention is the assumption of control on behalf of the patient to the extent to which it is unsafe for the patient to be in control. We cannot escape this responsibility. The whole essence of professionalism is recognizing our nursing responsibilities, acting on our nursing judgments, and being accountable for our nursing behaviors.

Your comments seem to be addressing a philosophical issue rather than a professional issue. In the words of Lisa Robinson, " ... a dead person is not one whose psychological condition can be modified." The nurse puts the patient as well as all other patients and staff at significant risk if she does not assume control of the situation.

Your definition of control as other than caring, suggests that control can only be punitive or in the interest of meeting the nurse's needs. This is not the context in which the article deals with control. No mention of hostility is made in the article. Assaultive behavior and "fight or flight" responses are motivated by fear. If, however, the nurse assumes a punitive attitude, she is likely to provoke hostility.

Maslow's hierarchy of needs provides the rationale for meeting psychological and safety needs as a necessary prerequisite to the development of a therapeutic relationship. This includes controlling his environment so as to provide both physical and psychological protection. As indicated, these nursing measures are the means through which the relationship is established. Again referring to Lisa Robinson, "The nurse, through her ministrations, demonstrates to the patient that she not only is concerned but that she actually *will take care of the patient."* As the patient becomes more lucid, psychosocial needs can begin to be dealt with more directly. The nursing measures described should be required for a relatively short period of time, until the *acute* psychotic episode subsides, frequently less than a week.

The nursing interventions presented in this article can provide, and in fact do provide the basis for standardized nursing care plans in a number of Canadian hospitals on medical, surgical, obstetrical, and psychiatric units. As such, this standardized regime provides the basis for teamwork which is essential in caring for acutely psychotic patients. Skilled nursing judgments are basic to the implementation of such a nursing care plan.

Your comments emphasize the importance of nurses dealing with their own anxieties prior to and in such a way that patients are not the recipients of misdirect frustrations. Priorities in crisis situations mu be determined on the basis of safety for th patient, other patients in the setting, and sta If nurses are not comfortable with their ow feelings about taking control, the outcome m be disastrous.

If, for example, nurses put a mattress the floor even though they are very uncomfortable doing so, their own anxietie will be communicated to the patient, and s create a more unmanageable situation. If theyare not comfortable medicating patien who are acutely psychotic, then they will ha more difficulty doing so. The patient who i already terrified will quickly perceive their insecurity, and this in turn will have an escalating effect on his fear. As pointed out the article, staff need opportunities to practi these measures under careful supervision order to develop their skills and to deal wi their own anxieties.

The context of the article is the safe, efficient, humane management of the acute psychotic patient by the nurse in any hospi setting. As Lisa Robinson expresses it, "Patients who cannot care for themselves a afraid, but when they see that others are strong and firm and able to care for them, th tend to be less frightened."

Robinson, Lisa. *Psychiatric Nursing as a Human Experience.* Toronto. W.B. Saunde Co. 1972.

Clinical Wordsearch no. 6

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has four words. *(Answers page 27).*

R E S S A L G H Y T E I X N A S D
N E V U N D O Y P S E N I L E M E
O M A I L S S P R I D E C P O Y M
I O L C I C E O I K D O S D S F E
T T I D T H L C M C H Y I A A E N
A I U E H I F H A O C F T I S A T
M O M U I Z O O L H Y N X D I R I
I N S C U O O N O S A E N L S P A
L S T I M I O D F F R I I A O R D
B E R N E D R R E O M U Y I R O E
U G E A N A E I N V R D G N U J D
S O S M M U B A N O I M D E E E R
D N J A D A Y C A R E A A D N C A
G R O U P T H E R A P Y T T S T T
N O I T A S N E P M O C M I I I E
S E N I Z A I H T O N E H P O O R
S O C I O P A T H Y H T A P A N N

1 Sigmund or Anna. *(5)*
2 Treatment modality involving 8 - 10 persons at one time. *(5, 7)*
3 Developed Reality Therapy. *(7)*
4 A type of scream. *(6)*
5 No it's not. *(6)*
6 A defence mechanism by which one adopts an attitude opposite to the repressed, unacceptable one. *(8, 9)*
7 Partial hospitalization. *(3, 4)*
8 A final answer to a stressful situation. *(7)*
9 The most over-prescribed minor tranquilizer. *(6)*
10 An addicting chemical used by some to escape from distressing situations. *(7)*
11 A coping mechanism by which one attempts to make up for real or imagined deficits. *(12)*
12 Snoruise (anagram)
13 A personality disorder resembling schizophrenia. *(8)*
14 Predominant feature of Altzeimer's disease. *(8)*
15 Doun (anagram)
16 The imaginary invalid was one. *(13)*
17 He doesn't sound old. *(4)*
18 Too much of this prevents some people from seeking help. *(5)*
19 A mental mechanism by which one attributes one's own unacceptable feelings or traits to another person. *(10)*
20 Fels (anagram)
21 The process of diverting socially unacceptable instinctive drives into socially acceptable behaviour. *(11)*
22 Emotion caused by specific impending danger. *(4)*
23 Eric's the name, transactional analysis the game. *(5)*
24 Generalized feeling of discomfort or apprehension. *(7)*
25 Any behaviour that varies from that considered socially acceptable. *(9)*
26 Loss of appetite, often psychogenic, may result in cachexia. *(8)*
27 Sigmund, his self. *(3)*
28 Feelings. *(8)*
29 Absence of feeling. *(6)*
30 A treatment modality involving a protagonist, an alter ego, and a director. *(11)*
31 McMurphy in "One Flew Over the Cuckoo's Nest" might have been one. *(9)*
32 Hans Selye's claim to fame. *(6)*
33 Electroconvulsive therapy. *(5)*
34 Hyperactive stage of a bi-phase psychosis. *(5)*
35 Pertaining to changes resulting from the aging process. *(6)*
36 Drug, useful in 34. *(7)*
37 What behaviourists attempt to do for their clients' problems. *(6)*
38 Depression marked by slowness of thought and action. *(8)*
39 Family of major tranquilizers. *(14)*
40 Usually found over matter. *(4)*
41 A daydream. *(7)*

Calendar

June

Second National Nurse Practitioner Symposium to be held in Denver, Colorado on June 23-25, 1977. Contact: *Primary Care Nurse Practitioner Symposium, University of Colorado School of Nursing, Continuing Education Services, C-287, 4200 E. Ninth Ave., Denver, Colorado, 80262.*

78th Annual Conference of the Canadian Public Health Association to be held in Vancouver, B. C. on June 28-30, 1977. Contact: *CPHA, 1335 Carling Ave., Suite 306, Ottawa, Ontario, K1Z 8N8.*

July

Futuration '77. The 12th Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, Winnipeg, Manitoba in July 10-15, 1977. Information: *Conference Manager, Futuraction '77. The Alcoholism Foundation of Manitoba, 1580 Dublin Ave., Winnipeg, Man., R3E 0L4.*

Dilemmas in Treatment a conference on dilemmas in psychotherapies and medical practice. To be held on July 24-29, 1977 in Venice, Italy. Fee: $85 Contact: *Clara Shapiro, Center for Policy Research, 475 Riverside Drive, New York, 10027, U.S.A.*

August

Health Care Evaluation Seminar. A one-week seminar for those interested in health care evaluation to be held at Memorial University of Newfoundland, from August 29-Sept. 2, 1977. Applications due June 1. Contact: *Patricia Bruce-Lockhart, Division of Community Medicine, Faculty of Medicine, Memorial University of Newfoundland, St. John's, Newfoundland, A1B 3V6.*

Strategies for Curriculum Change. To be held in Winnipeg, Man. on August 18-20, 1977. Contact: *Institute of Nursing Consultants, Fay Bower, 1820 Portola Road, Woodside, California, 94062.*

Symposium on Canada and World Food to be held at Carleton University, Ottawa on August 22-24, 1977. Multidisciplinary topics discussed. Contact: *The Royal Society of Canada, 344 Wellington St., Ottawa, Ont., KIA 0N4.*

World Federation for Mental Health - 1977 Congress, "Today's Priorities in Mental Health," to be held in Vancouver, B.C. from August 21 - 26, 1977. The focus of the meeting will be on finding ways to make health systems work for all the people, including the mentally ill. Techniques of Health By The People will be emphasized. For further information contact: *Secretariat, World Federation for Mental Health, Health Sciences Centre Hospital, 2075 Wesbrook Place, The University of British Columbia, Vancouver, B.C. V6T 1W5.*

September

Emergency Nurses Association of Ontario Annual Conference to be held September 12-14, 1977 at the Skyline Hotel, Ottawa, Ontario. Contact: *Helen McPhee, Supervisor, Emergency Department., Ottawa Civic Hospital, 1053 Carling Ave., Ottawa, Ontario.*

Fourth Annual Meeting of the Ontario Psychogeriatric Association to be held on Sept. 19-21, 1977. Theme: Bringing Continuity to Care. Contact: *Dr. M. Farquhar, P.O. Box 14, Postal Station "C", Toronto, Ontario, M6J 3M7.*

Initial Assessment and Management of Patients with Acute Illness and Injury. A two-day seminar sponsored by the Emergency Nurses Group, a special interest group of the RNABC. To be held on Sept. 30 - Oct. 1, 1977 at the Four Seasons Hotel, Vancouver, B.C. Contact: *Linda J. Clark, c/o Emergency Nurses Group, Box 86824, North Vancouver, B.C.*

October

Sixth Annual General and Scientific Meeting of The Canadian Association on Gerontology to be held October 13-16, 1977 in Montreal at Loews "La Cite" Hotel. Contact: *Blossom T. Wigdor, Ph.D., Director, Psychology Services, Queen Mary Veterans Hospital, 4565 Queen Mary Road, Montreal, Quebec, H3W 1W5.*

28th Annual Meeting of the Ontario Public Health Association to be held on Oct. 18-21, 1977 at the Skyline Hotel in Rexdale, Ont. Contact: *Kae Sutherland, OPHA, 7 Carlis Place, Port Credit, Ontario, L5G 1A8.*

12th Operating Room Nurses Conference to be held by the O.R. Nurses of Nova Scotia on Oct. 18-20, 1977 in Halifax. Contact: *Miss L. Hirtle, R.N., Halifax Infirmary (OR), 1335 Queen St., Halifax, Nova Scotia.*

November

First Annual Nurse Educator Conference to be held at the Hyatt-Regency Hotel in Chicago, Ill. on November 7, 8 and 9, 1977. Theme: Transition from student nurse to effective professional. Contact: *S. Swartz, 12 Lakeside Park, 607 North Ave., Wakefield, Mass., 0l880.*

Canadian Nurses Foundation

Have you forgotten to renew your 1977 CNF membership?

Are you thinking of becoming a member?

Money donated by nurses to the Foundation is used to support nursing scholars and nursing research.
Since 1962 144 nurses have been awarded 174 CNF Fellowships. Thirty nurses have been funded twice.

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Ottawa, Canada, K2P 1E2.

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Sustaining member ($50.00) _____
Patron ($500.00) _____

Donation (membership not included) to
Scholarship _____ Research _____
Capital Trust _____ Administration _____

Name _____
Address _____

Amount of cheque for the year 1977 _____

Contributions to the Canadian Nurses Foundation are deductible for income tax purposes

Information is supplied by the manufacturer; publication of this information does not constitute endorsement.

What's New



Recreation Equipment for the Disabled

"Total Function Recreation Equipment for the Disabled," is the title of an all new, eight-page catalog supplement issued by Maddak Inc., subsidiary of Bel-Art Products.

Featured are such equipment as table tennis, pool tables, bumperpool, miniature bowling alleys, bowling ramps and a host of table top games. "Total Function" is achieved through the adjustable table height design which permits use in regular and adapted programs and accommodates individual requirements of height, age and ability.

This brochure is available free, by writing to Maddak Inc., Pequannock, N.J. 07440.

Visual Scheduling System

A visual staff scheduling system, the Beanstalk, consists of wall-mounted modular grid boards and inch square colored cardboard tabs clipped into plastic holders. The tabs can be written on and dropped firmly into place anywhere in the grid pattern.

The system provides a complete overview of the nursing staff complex at a glance, yet the system itself is simple and easy to maintain.

Details of this system and many similar applications are available from: Kentron Services, 50 Firwood Crescent, Islington, Ontario M9B 2W2.

Computer Health Testing System

International Health Systems, Inc., of Illinois has introduced a new vertical configuration of the Computa-Lab DSN, hospital information and health testing system. The Computa-Lab System is portable so that it can be wheeled into plants, offices or other locations. It requires as little as 150 square feet of work space but meets the same performance capabilities as the standard Computa-Lab system.

Up to 50 patients a day can be tested using this system. Complete procedures including history taking, physiological testing, and collection of specimens for laboratory testing can be performed by one to three technicians in less than an hour. Most of the testing is performed as the patients relax comfortably in chaise lounges.

Patient health histories are taken automatically by the Computa-Lab Audio-Response Unit. The patient listens to a recorded program of history questions, pressing buttons to give the computer his answers.

Foreign language and custom history programs are readily available.

All test information and data are printed out by the systems computer as soon as testing is completed.

The Computa-Lab system includes instrumentation for a 12-lead E.C.G., pulmonary function testing, tonometry, blood pressure, audiometry, vision testing, anthropometry and temperature.

The system is equipped for computer interpretation of ECG's. ECG interpretation and biochemical profiles are offered as optional services. The manufacturer provides training for operating personnel and equipment maintenance.

For further information, write: International Health Systems, Inc., 3603 Edison Place, Rolling Meadows, Illinois 60008.

Multi-Position Foot Board

The Multi-Position Foot Board is designed by Lumex Inc. to help prevent and/or correct foot drop and foot rotation, and provide comfortable immobilization at prescribed position.

The board acts as a bed cradle, keeping bedding off patient's feet; it fits any standard hospital bed, can be installed/removed without tools, and can be positioned anywhere on the bed to accommodate short or tall patients, without interfering with gatch. The board can be used with side rails up or down and mounting arrangement eliminates heel pressure. The foot board can also be tilted and the triangular positioning blocks can be rotated to any desired position. Removable blocks are adjustable to any width.

The board is of molded, structural foam construction, and is easy to keep clean. It measures 15"x36"x4 1/2".

For further information contact: Lumex, Inc., 100 Spence Street, Bay Shore, N.Y. 11706.

Electronic Thermometer

The new LaBarge Model 12 Electronic Thermometer saves both time and money by providing an accurate temperature reading in less than 30 seconds. It features a unique LED (light emitting diode) display that permits simultaneous readings in both fahrenheit and centigrade.

A tough Lexan case and all solid-state circuitry make the Model 12 durable enough to withstand constant hospital service. Replaceable batteries provide portability and give six months' normal use before replacement is necessary.

The LaBarge Model 12 Electronic Thermometer includes separate oral, rectal and continuous monitoring probes. In addition, a special plug-in module provides an easy method of verifying calibration of the unit in the hospital. The new Model 12 Thermometer uses LaBarge's patented disposable SteriTherm covers, which are available in both oral and prelubricated rectal form.

For further information, write: Mark J. LaBarge, LaBarge Inc., 500 Broadway Building, St. Louis, Missouri 63102.

Kolaps-A-Tank for Hyperpyrexia

The Kolaps-A-Tank, a new, lightweight, collapsible immersion tank designed to meet critical need for immediate treatm in cases of malignant hyperpyrexia now available from Burch Manufacturing Co.

The Kolaps-A-Tank weighs o 10 lbs., can be set up in only eig seconds by one person, fits any standard size O.R. stretcher cart, permits patient treatment to be car out at a normal working level.

The Kolaps-A-Tank features: sturdy, aluminum frame; bacterial-resistant tank material; drain outlets; detachable cover wi permits easy cleaning; storage po with grommets for convenient, accessible wall mounting.

The 72"x26"x14" vessel can folded up for compact storage.

For more information contact: Burch Manufacturing Co., Inc., F Dodge, Iowa 50501.

Built-in Hyper/Hypothermi Systems

Gaymar Industries Inc., now offers built-in hyper/hypothermia systems for areas such as ICU, O Critical Care areas, and recovery rooms. Two styles of units are available with these custom desig systems. One is a movable wall u and the other is an in-wall, flush mo control unit.

The system offers a number features: savings on floor space critical hospital areas; easier acc to the patient; convenient locatio equipment for nursing care; reduc of noise and heat; aid in eliminat cross-contamination potential; reduction of leakage current level the electrical load on isolation transformers; instant hypothermi with 40° blanket water always available.

Systems are compatible with patient head walls. Built-in syste are designed to meet customer requirements.

For information contact: Gaym One Bank St., Dept. 501, Orchar Park, New York, 14127.

Canesten

Antifungal and trichomonacidal agent clotrimazole

PRESCRIBING INFORMATION

INDICATIONS *Canesten Cream and Solution* Topical treatment of the following dermal infections tinea pedis, tinea cruris and tinea corporis due to T rubrum, T mentagrophytes and Epidermophyton floccosum, candidiasis due to C albicans, tinea versicolor due to Malassezia furfur

Canesten Vaginal Tablets Treatment of vaginal candidiasis and trichomoniasis. Canesten Vaginal Tablets may be used in both pregnant and non-pregnant women, as well as in women taking oral contraceptives (See Precautions)

DOSAGE AND ADMINISTRATION *Cream and Solution* Thinly apply and gently massage sufficient cream or solution into the affected and surrounding skin areas twice daily, in the morning and evening

For vulvitis Canesten Cream should be applied to the vulva and as far as the anal region For balanitis and prevention of vaginal infection or reinfection by the partner Canesten Cream should be applied to the glans penis

Vaginal Tablets One tablet a day for six consecutive days Using the applicator, insert one tablet deep intravaginally, preferably at bedtime In order to avoid treatment during menstruation, it is suggested that treatment be started at least 6 days prior to the anticipated menstrual period

DURATION OF TREATMENT *Cream and Solution:* The duration of therapy varies and depends on the extent and localization of the disease Generally, clinical improvement with relief of pruritus usually occurs within the first week of treatment Tinea infections require approximately 3-4 weeks of therapy while in candidiasis, 1-2 weeks treatment is often adequate If no clinical improvement is observed after 4 weeks, the diagnosis should be reviewed

If a cure is not mycologically confirmed or in order that relapses may be prevented (particularly in mycoses of the foot), treatment should, as a rule, be continued for 2 weeks after all clinical symptoms have disappeared

Vaginal Tablets The six-day therapy may be repeated if necessary

SPECIAL REMARKS *Cream and Solution* Added hygienic measures are of special importance in the management of the often refractory fungal diseases of the foot To avoid trapped moisture, the feet — particularly between the toes — should be dried thoroughly after washing

Onychomycoses, owing to their location and physiological factors, generally respond poorly to topical antimycotic therapy alone due to poor penetration into horny substance. Treatment with Canesten may be considered in cases of paronychia and as adjunctive therapy in onychomycoses following extraction or ablation of the nail

Vaginal Tablets Added hygienic measures such as twice daily tub baths and avoidance of tight underclothing is highly recommended

In the case of clinically significant trichomonal infection, additional therapy with a systemic trichomonacidal agent should be considered Such therapy is essential for the treatment of vaginal infections which may also involve Bartholin's glands and the urethra

CONTRAINDICATIONS Except for possible hypersensitivity, Canesten Solution, Cream and Vaginal Tablets have no known contraindications

PRECAUTIONS As with all topical agents, skin sensitization may result Use of Canesten topical preparations should be discontinued should such reactions occur, and appropriate therapy instituted

Canesten Solution and Cream are not for ophthalmic use Canesten Vaginal Tablets are not for oral use

Use in Pregnancy Although intravaginal application of clotrimazole has shown negligible absorption from both normal and inflamed human vaginal mucosa, Canesten Vaginal Tablets should not be used in the first trimester of pregnancy unless the physician considers it essential to the welfare of the patient

The use of the supplied applicator may be undesirable in some pregnant patients, and digital insertion of the tablets is an alternative which should be considered

SIDE EFFECTS Large scale clinical trials have shown that Canesten is very well tolerated after topical and vaginal application

Cream and Solution Erythema, stinging, blistering, peeling, oedema, pruritus, urticaria, and general irritation of the skin have been reported infrequently

Vaginal Tablets Skin rash, lower abdominal cramps, slight urinary frequency, and burning or irritation in the sexual partner have occurred rarely In no case was it necessary to discontinue treatment with Canesten Vaginal Tablets

AVAILABILITY *Canesten Solution* 1% is supplied in 20 ml plastic bottles in cartons Each ml contains 10 mg of clotrimazole in a non-aqueous vehicle

Canesten Cream 1% is supplied in 20 g tubes in cartons Each g contains 10 mg of clotrimazole in vanishing cream base

Canesten Vaginal Tablets 100 mg are supplied in boxes containing one strip of six tablets with plastic applicator and patient leaflet of instructions

REFERENCES 1 Lohmeyer H Postgrad Med J 50 Supp 78 1974 2 Schnell J D Ibid p 79 3 Legal H P Ibid p 81 4 Widnolm O Ibid p 85 5 Couch Jr an J M Ibid p 93 6 Higton B K Ibid p 95 7 Oates J K Ibid p 99 8 Masterton M B et al Curr Med Res Opin 3 83 1975 9 Sawyer P R et al Drugs 9 424 1975 10 Postgrad Med J 50 Suppl 54 76 1975

For further prescribing information please consult the Canesten Product Monograph or your Boehringer Ingelheim representative

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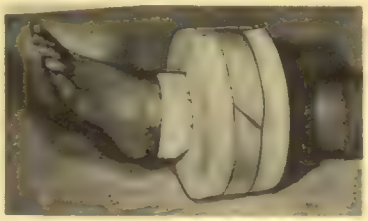
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POSEY FOR PATIENT COMFORT

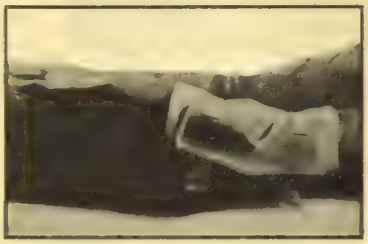
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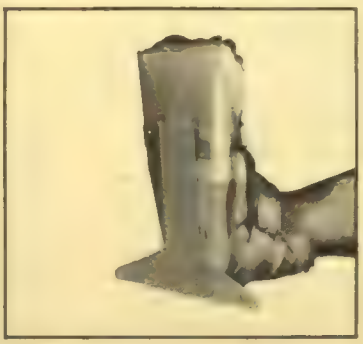
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The Posey Elbow Protector helps eliminate pressure sores and friction burns. Three models are available. *#6220 (synthetic fur w/out plastic lining),*



The Posey Foot-Guard with new "T" bar stabilizer simultaneously keeps weight of bedding off foot, helps prevent foot drop and foot rotation. *#6412,*



The Posey Ventilated Heel Protector helps prevent friction and skin breakdown while allowing free movement. The newly developed closure holds heel protector on the most restless patient. *#6110 (w/plastic shell),*

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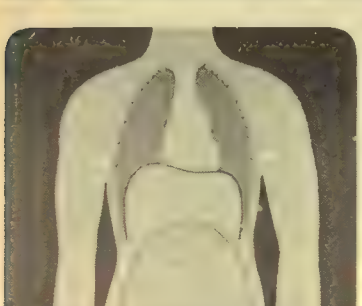
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Audiovisual



Maternity

Breathing Exercises for the Expectant Mother

A 15-minute 16mm color sound film directed by Marie-Elizabeth Taggart, Assistant Professor, Faculty of Nursing, University of Montreal, Montreal, Quebec. This film is about preparation for childbirth through the instruction of various breathing techniques designed to help the mother attain successful, conscious childbirth. It explains the process of normal respiration and the changes in normal respiration during pregnancy. Through silhouette animation, the film reviews and explains different types of breathing to be used during each stage of labor and childbirth. It may be used for teaching expectant mothers in prenatal classes, student nurses or health education trainees. An independent Canadian production available in the French language as "Exercices de respiration pour la femme enceinte." Approximate price $200; available for preview when there is intent to purchase for $15.00, applicable to purchase price. For information, contact: Cinédessins, Reg'd., P.O. Box 430, Mount Royal Station, Montreal, P.Q. Canada, H3P 3C6.

The Neurological Evaluation of the Maturity of New Newborn Infants

This 32-min. color film uses stick figures and live infants to demonstrate neurological gestational age assessment. Infants at 30 wks., 34 wks., 36 wks., and 38 wks., are examined, and stick figure diagrams are used to show where the infant is in neurological development. A general summary of neurological assessment is given at the end of the film. The film assumes some familiarity with the newborn, terminology associated with neurological examination and pediatrics. Available in 16 mm and in 3/4 inch video-cassette, for rent or purchase from the Health Sciences Communication Center, Case Western Reserve University School of Medicine, 2119 Abington Road, Cleveland, Ohio 44106.

Health Promotion

Canada Safety Council Brochures

The Canada Safety Council publishes brochures and educational materials that are helpful in teaching and promoting accident prevention. They are available from the Canada Safety Council, 1765 St. Laurent Blvd., Ottawa, Ontario, KIG 3V4. Some examples are:

- *Selecting the right toy for the right child* — a two-color pamphlet, gives suggestions for toys suited to the child's age and ability. Hazards to avoid are listed. Costs up to 7 cents each depending on number ordered. Minimum order 10.
- *Home workshop, electrical power tool safety* — six-page, two-color booklet deals with common unsafe acts and conditions in home workshops. Up to 10 cents each, minimum 10.
- *Guide for home safety* — eight-page, two-color booklet on prevention of accidents in the home. Includes a home safety check list Up to 10 cents each, minimum 10.
- *Babysitters' course* — designed and packaged to facilitate the training of part-time babysitters. One kit (at $10 each) contains materials and information to conduct a course for 20 students.
- *Guide for child safety*— two-color pamphlet about preventing child accidents in the home from birth to school age. Up to 7 cents each, minimum 10.
- *Prevent falls* — two-color pamphlet with facts on accidental falls, their causes and how to prevent them. Up to 7 cents each, minimum 10

Your Move

This 22-min. color film is a persuasive appeal to Canadian women to get fit. A recent study concluded that 47 percent of Canadian women rate low to fair in physical fitness. This film challenges women to change that image and shows the many sports that modern women are becoming involved in. Available from the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario KIZ 6X3.

What's Good to Eat?

An 18-min. color film discusses the importance of skillful choice when planning a varied diet. A 12-year-old boy learns to use the four food groups as a way to get the nutrients he needs. Available from the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario K1Z 6X3.

Mental Health

No Tears for Rachel

This is a 27-minute, color film dealing with how the rape victim copes with a cold legal process and the unpredictable reactions of her friends and family. In order to prosecute, the victim must undergo a physical examination, detailed questioning and a face-to-face confrontation with her attacker in court. One woman discusses the difficulties she experienced when she told her friends that she had been raped. Her psychiatrist explains the importance of their reactions and the stigma associated with being raped. To request this film contact the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario.

One Step Ahead

A 28-min. film dealing with crisis control. It shows how to deal with a disturbed person humanely, without causing emotional trauma, injury or physical pain by being "one step ahead" of any situation. Accompanied by a 23-page training manual (with 70 illustrations), the program explores the various types of emotional crisis situations and presents viable solutions based on the degree of violence involved. The film is available for purchase or for rent from Motorola Teleprograms, Inc., 4825 N. Scott St. Suite 23, Schiller Park, Ill. 60176.

Emergency Treatment of Acute Psychotic Reactions due to Psychoactive Drugs

Produced by the Addiction Research Foundation, this 17-min. black-and-white film shows the program at Hotel Dieu Hospital in St. Catharines for treatment of drug-related emergencies. Available in 16 mm from the Librarian, Canadian Hospital Association, 25 Imperial St. Toronto, Ontario M5P 1C1.

Audio Cassettes

How to Communicate

This is an audio cassette program that presents successful techniques for effective communication, designed for health administrators.

The 4 cassettes cover such topics as: how to handle face-to-face communication, how to be a "creative listener," how to communicate effectively in writing, how to distinguish between fact and opinion, how to improve relations with the public and with patients, and how to tell the press what they want to know.

For more information about *How to Communicate Effectively* and other programs for health workers, write: Tech'em Inc., 625 N. Michigan Ave., Chicago, IL 60611, U.S.A.

Patient Teaching

Hospital-tested educational cassettes for patients and their families describe what doctors want their patients to know about 4 common illnesses: diabetes, emphysema, gout, and hypertension.

Developed by faculty members at Chicago's Northwestern University Medical School, the series uses language that patients can understand, to provide a basis for them to use time with the attending physician more effectively.

Information about the 4-cassette package is available from: Teach'em Inc., 625 N. Michigan Ave., Chicago, IL, 60611, U.S.A.

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Research

Suicide

A Comparative Study of the Self-acceptance of Suicidal and Non-suicidal Youths. Vancouver, B.C., 1976. Thesis (M.Sc.N.) U.B.C. by *Catherine Ann Westwood*

Youths who attempt suicide may ave many negative feelings about nemselves which are manifested in a ow level of self-acceptance. This



actor is often overlooked in specific assessment and intervention measures. Nurses, because of their location in schools, are in a unique position to recognize and intervene with the potentially suicidal youth. Nurses however may have difficulty in recognizing the youth with poor self-acceptance.

This exploratory study was undertaken in order to answer the question: "is a low level of self-acceptance in youths age sixteen to twenty-five correlated with suicide attempts?" The answer was sought from information obtained from youths' self-reports on the Berger Scale of Self-Acceptance and the California Psychological Inventory. These tests were administered to thirty youths divided into three groups. Group A were suicide attempters seen in the emergency ward of a large general hospital, group B were non-suicide attempters seen in the emergency ward and group C were chosen from the community.

An analysis of variance was carried out to discover if there was a significant difference in self-acceptance among the three groups.

The findings supported the overall conclusion: youths between ages sixteen and twenty-five who attempted suicide had a significantly lower self-acceptance than control group youths. The variable of hospitalization did not affect self-acceptance.

• Maternity

Selected Aspects of the Childbearing Experience as Described by Sixty Couples. Nursing research conducted at the School of Nursing, University of British Columbia, Vancouver, B.C., 1976 by *Helen Elfert and Linda Leonard.*

This study describes aspects of the experience of sixty couples during pregnancy, childbirth and the immediate postpartum period. The couples were selected in a semi-random fashion from patients in two maternity units in Vancouver, B.C. The two maternity units were similar in some respects, e.g. husband participation in labor and delivery, and differed in other areas, e.g. visiting regulations and participation of parents in infant care.

The data showed a high level of involvement of the couple in planning for labor and delivery, with two-thirds attending prenatal classes. Nearly all husbands expected to be present during labor and 75% expected to see the delivery. In addition 78% of women chose to breast-feed their infants. There was less apparent decision-making related to where the baby would be born; fewer than half had made a deliberate decision about what hospital they would go to, and some knew nothing about the unit prior to admission.

Overall, couples in both settings expressed satisfaction with their hospital care and experience; specific areas of concern were identified. There was somewhat higher satisfaction and feeling of control in the unit in which there is greater parental participation in infant care.

Recommendations are made for further study, and possible changes in maternity care are suggested.

• Emergency

A Study of Continuity of Nursing Care from the Hospital Emergency Room into the Home. Toronto, Ont., 1976. Thesis (M.Sc.N.), University of Toronto by *Catherine Ann Perkin.*

The specific purpose of this study was to describe the observed and expressed nursing needs of patients following discharge from the hospital emergency room. The ultimate purpose was to contribute to an improvement in the quality of nursing care received by patients using the emergency room where contact is brief and focuses on a presenting complaint.



In this descriptive study, 30 patients between 20 and 75 years of age were identified during their contact with the emergency room and then interviewed on one occasion at home. Data were collected using a highly structured interview schedule prepared and administered by the investigator. Patients' responses to questions were analyzed under the following headings: selected patient characteristics; utilization of medical care; patient perceptions of the kind, source and amount of information received; patient-perceived gaps in care and the observed and expressed nursing needs of these patients including direct nursing care, rehabilitation, health supervision, and emotional support needs.

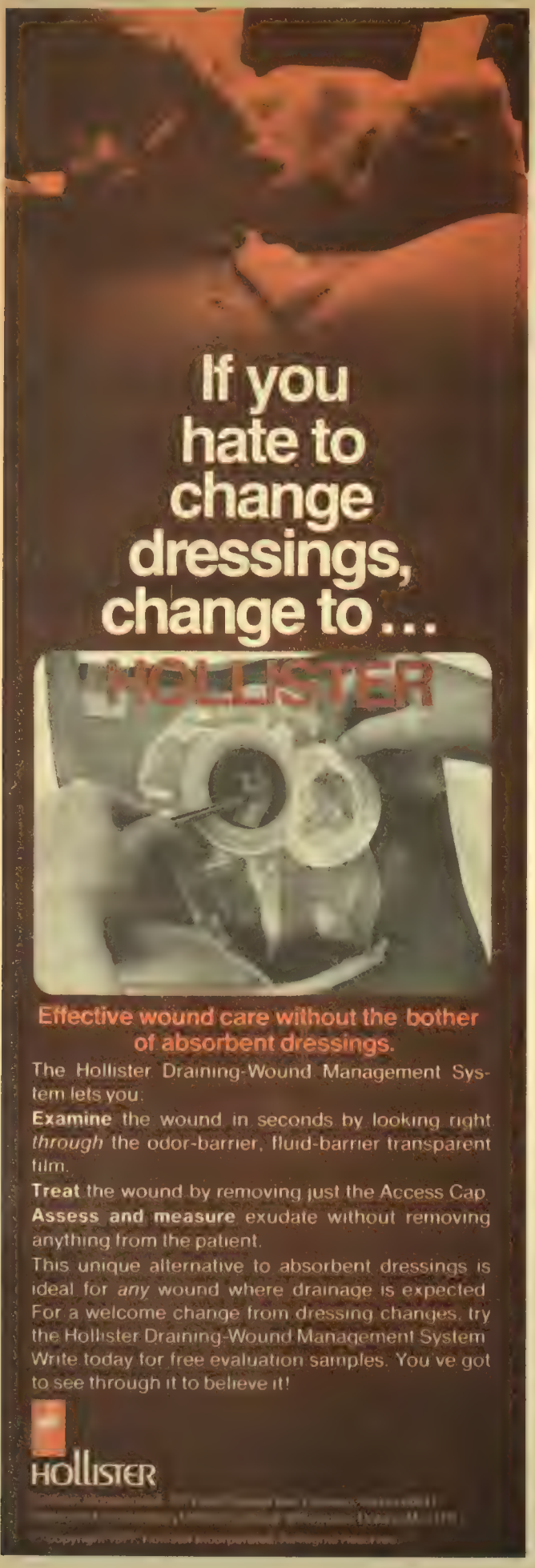
The findings showed that the doctor was perceived by patients to be the source of most useful information regarding the diagnosis and plans for treatment. An analysis of the observed and expressed nursing needs and patient comments regarding gaps in care described in this study reveals that patients want and need more specific information both about their health condition and instructions for continuing care related to drugs, treatments, exercise and/or rest and diet. The concerns expressed by some patients about the kind and amount of information they received were associated with the non-specific nature of information, not having questions answered or instructions repeated so that they might be understood more readily.

The need for further health supervision was related to some of the following areas: lack of knowledge regarding medication including the expected results or possible side effects; possible complications of immobility and appropriate preventive measures; specific descriptions of types and amounts of food or fluids. It appeared that receiving written instructions was useful for patients in helping them to follow the plan of care. Although the data revealed that there was provision for continuing medical supervision, similar provision for continuing nursing care or supervision was not evident.

It is important that while in the emergency room, the patients' home responsibilities and sources of help be assessed by nurses so that alternate resources can be utilized.

Findings related to the need for emotional support indicated common areas of concern expressed by patients about the outcome of their condition, lack of necessary knowledge about the diagnosis or treatment, anxiety in other family members and changes in life style.

Implications are stated for nursing practice, education and research. Generalizations are limited because of the size and nature of the sample. However, the findings in this study do suggest areas of nursing need and patient-perceived gaps in care which impede the flow of continuous and comprehensive care. It is apparent that patients want and need more specific information about their health problem and instructions for continuing care. It is important that nurses take an active role in patient teaching, interpreting and clarifying instructions and anticipating common patient questions and concerns.



Research

- **Labour and Delivery**

Husband-Father's Perceptions of Labour and Delivery. Vancouver, B.C. 1975. Thesis (M.SXC.N.), U.B.C. by *Linda Gaye Leonard.*

This study was concerned with the husband-father's perceptions of labour and delivery; how he perceived his role during this period; and his perceptions of the nursing care provided to his wife and himself.

Sample selection was by random sampling and included twenty husbands. All were Caucasian, Canadian or British born, between the ages of twenty-two and forty years of age, and all had attended prenatal classes. Eighteen fathers attended the delivery. Seventeen were fathers for the first time and three were fathers for the second time.

Data were obtained via one hour-long interview with the husband during the first three days postpartum. An interview schedule was used and contained rating scales, fixed-alternative and open-end questions. Findings showed:
— that labour and delivery were seen by the husband as being positive experiences, with delivery being the most positive,
— that the husband focused his attention during labour on his wife until late second stage when it shifted to the baby and to his own feelings,
— that the labour was stressful for many of the husbands who were uneasy seeing their wives in pain,
— that the major function of the husband in labour was to provide moral support, encouragement, and bodily care to his wife. Most felt that they were effective in their role but needed to confirm this with their wives.
— that prenatal classes were viewed as having a positive influence on husbands' attitudes toward labour and delivery.
— that the attitudes and responses of the nurses during labour and delivery had a significant effect on the husband's confidence and relaxation.
The major weaknesses of the nursing care were the inadequate assessment, explanation, and nurse contact time during the active phase and second stage of labor.

The study results have implications for the prenatal preparation of couples, for care of th parents during labour, delivery, an the early postpartum period. Recommendations for future study, centered on the need for more information about husband-father response during labour and deliver early responses to the newborn; an information about the effects of husband-father participation in childbirth on the husband-wife-chil relationship.

- **Patient Teaching**

Postoperative Cardiac Surgical Patients' Opinions about Structured Preoperativ Teaching by the Nurse. Birmingham, Alabama, 1974. Thesis (M.Sc.N.), University of Alabama in Birmingham by *Louise Dumas.*

In this study, the author tries to analyze the responses of postoperative cardiac surgical patients to a questionnaire on their opinions regarding preoperative teaching by the nurse. She attempts t find out if these patients express a desire to receive information about their preoperative, operative, and postoperative periods through such teaching. She then attempted to fin out if patients, following the same research criteria but in a different milieu, would have liked to be informed preoperatively by identica teaching.

Thirty-six patients answered th questionnaire, developed by the investigator from the teaching plan used in her previous research. The results clearly show the desire of th patients to have received preoperati structured teaching and given, preferably, by the nurse. All the questions (43), on the possible content of such a teaching program indicate 75% to 100% positive answers, showing the preoperative needs and the postoperative worrie of these patients.

This investigation is followed by discussion of the results, some recommendations for nurses and future researchers, and some tools fo patient education.

Books

Plus ça change ... Abortion then and now

The findings of the Committee on the Operation of the Abortion Law only confirm what most of us have known since the end of the first year of the liberalized abortion law, namely: that the abortion law is not being interpreted and enforced equitably across Canada and the consequences of this fact tend to victimize the already disadvantaged, the young, less educated and newcomers to the country. The Committee was asked only to provide findings on the operation of the 1970 liberalization of the Abortion Law which permits women to be certified by a hospital committee of three qualified medical practitioners for abortion if their life or health is endangered. The committee was not asked to consider the merits of the abortion law itself or to make recommendations.

Report of the Committee on the Operation of the Abortion Law
to the Minister of Justice by Robin F. Badgley, Chairman. 474 pages. Ottawa, Supply and Services, January, 1977.
Price $6.75
Reviewed by Nancy Garrett formerly pediatric associate, Harvard MCH program, University Health Sciences Centre, Cameroon.

The report contains a good deal of provocative material on this still emotive subject. One surprise was the high failure rate of contraceptives — if one can believe this finding. The usual oral contraceptive pill failure is in the range of 0.08%. The patient survey rate cited in the Report emerges at 18% which brings up the question of Chapter 14, Sexual Behavior and Contraception.

This subject is well supplied with tables of statistics but the psychology of contraception and sexual intercourse might profitably have been mentioned as a possible explanation of the unacceptable "rates of failure." Everyone who works with teenagers has heard of the young girl who confidently explains that she takes a pill just before going out with her friend.

Other more traditional young girls cannot morally anticipate (and therefore prepare for) sexual intercourse, so their "sin" can be justified by "being swept away with passion." One modern type naively wants everything to be spontaneous and "natural" so contraception is out. The feminist radical wants her rights respected to govern her own body. These and other obstacles negatively influence contraceptive use and lead to conclusions like the committee's allegation that education on contraception seems to make little difference to unwanted conception because abortion seekers who had not received school instruction on contraception used the same contraceptives as those who had.

The committee conversely states that appropriate contraceptive use reduces the chance of conception and it believes abortion rates will not be contained without coordinated public education programs and health promotion and research to find improved contraceptives. The report indicates that public health and community agencies have not had significant impact on public knowledge. Most people rely on their physician for information. But sexuality education was only added to medical education curricula in 1970 which may in part account for the number of uninformed and partially informed respondents. The report points out that young people do not request contraceptive information when visiting physicians for other reasons. Media information was conspicuously lacking in survey responses to the question on contraceptive information sources.

The type and consistency of contraceptive use in the instructed and non-instructed groups was not evaluated. Neither was the use of Menses Induction, withdrawal of a little of the uterine lining with a syringe, performed in the doctor's office like an IUD insertion, up to 40 days after unprotected intercourse (a method believed by some to be the answer to preventing abortion).

The fact that repeat "offenders" are twice as likely to have a college education tends only to add weight to the psychology or philosophy problem discussed above.

The committee admits that, "little is known, because there is much stigma involved, *little has wanted to be known,* about the socially rejected outcomes of sexual intercourse." (p. 325-26).

Throughout the report, an overtone of the illicitness of the subject prevails. An unwanted pregnancy seems somewhat akin to having a social disease and the abortion seeker to having a defective character. Health care providers also seem punitive in their references to "repeat offenders." The committee notes that "many physicians and nurses have voiced their deep concern about abortion patients who obtain this operation when their pregnancy is more advanced and they attribute this delay to the socially irresponsible behavior of women seeking induced abortions" (p.151). In fact the delays are unquestionably due to delays in securing medical decisions, sometimes requiring visits to several doctors, and processing by abortion review committees.

We cannot hope for a rapid switch to prevention by young people until they understand their sexuality better. Sexual activity does not start functioning at the arbitrary age decided by a physician who decides to withhold counselling until the girl is 17 or 18 years old. Neither can we expect health care workers to be happy about offering a socially rejected service which is most needed by young, uneducated, poor women who may also be handicapped by their newness to the country.

Delays, threats of sterilization requirements with abortion , extra billing especially of the young, less well-educated (poor), and pre-operative cash payments are reported to be victimizing the already distressed abortion patient.

Twenty-five of the 474 pages are tables including opinions of men and women on reasons for abortion and on their opinions of the abortion law. The statistical method and the abortion law are provided in the appendices. The terms of reference and summary of findings are easy to find in Chapter 3.

The report may provide enlightenment to those whose beliefs, (as evidenced by the hospital staff survey) are contradicted by facts, e.g. "I feel that allowing therapeutic abortion has not decreased back alley criminal abortions." (p. 298). It will be useful to authors of future papers because it brings together current, nearly comprehensive data, otherwise impossible or time-consuming to gather on attitudes and practice of Canadians receiving and providing health care services for contraception and abortion. Committee sources were surveys of physicians, hospital staff, patients and hospital agencies, the 1976 national population survey as well as visits and reports including use of abortion facilities outside Canada.

It should be read by both service providers and health manpower educators with a view to improving coordination and impact of programs offering contraceptive and sexuality education and services.

Health happenings

A fourth year student in applied human nutrition at the University of Guelph in Guelph, Ontario, has concluded that pharmacists are no more knowledgeable about vitamins than health food retailers and no more qualified to sell them. The most striking difference between the two, she found, was in their relationship with the consumer.

"The most impressive characteristic of the health food retailers was their sincerity. Most appeared to be extremely earnest in their goal of obtaining superior health through nutrition. They were all unusually amiable and comfortable to chat with.

"On the other hand, the pharmacists projected a colder image. Because of this, they were more difficult to approach and less willing to talk. Eye contact was hard to establish with the pharmacists since they were all stationed behind high counters."

Researcher Jane MacDonald who worked under the supervision of Dr. Zak Sabry, coordinator of the Nutrition Canada Survey, says she doesn't ordinarily take vitamin pills herself "except maybe during exams when I'm too nervous to eat."

Books

Toohey's Medicine for Nurses (11th Edition) by Arnold Bloom. 612 pages, London, Churchill Livingston, 1975.
Approximate price $12.50 Reviewed by Mary Rakoczy, Assistant Professor, Queen's University, School of Nursing, Kingston, Ontario.

The appearance of the eleventh edition of this book reinstates its value as a text for nurses. It is a useful reference for both the graduate nurse, and the nursing student.

Toohey's Medicine for Nurses is a referral for causes, signs, symptoms, and treatment. It is abundantly and clearly illustrated with diagrams, photographs and tables.

The table of contents is complete but not as detailed as it is in the tenth edition. The introductory chapter discusses the general pathology of the disease process, with an explanation of the terms. The succeeding chapters are grouped according to the systems of the body and the more common diseases are outlined within.

The concepts that one might consider as part of the whole are awarded their own chapters i.e., *Chapter 18, On Pain and Vomiting; Chapter 20, Psychological Medicine.* In Chapter 20, it is interesting to note that although the significant emotional components are included in the various medical conditions, the socioeconomic factors a not emphasized.

The author, a medical doctor, stresses the physiological principles underlying the medical disorders and their treatment. One detects no chauvinism but rather insight into the nursing process and support for it.

This edition has excluded the 'Trade Names Drugs' and the reference table of 'Chemical Nam and Drugs.' More serious omissions occur in th absence of selected references and specific nurs implications.

No doubt, there will be a twelfth edition of th text including the same high standard and ratio explanation of diseases and their management

News (continued from page 10)

Summary of Information on Malpractice Insurance Offered by Provincial/Territorial Associations as of 1 April 1977

Association	Malpractice Insurance Offered	Included In Membership Fee	Coverage Per Year
Registered Nurses Association of British Columbia	Yes	Yes	Up to $100,000 for three times in one year.
Alberta Association of Registered Nurses	Yes	Yes	Approximately $100,000 to $300,000 per year.
Saskatchewan Registered Nurses Association	Yes	Yes	Approximately $150,000 to a limit of $250,000 (in process of changing insurance companies).
Manitoba Association of Registered Nurses	Yes	Yes	$100,000 for single incident. $300,000 for more than one.
Registered Nurses Association of Ontario	Yes	No - (Voluntary $3.50 per yr.)	$200,000 per incident to a total of $500,000 in one calendar year.
Order of Nurses of Quebec	Yes	No ($15.00 per yr.)	$500,000 per year (includes previous years and for next thirty years — Quebec law.)
New Brunswick Association of Registered Nurses	Yes	No ($8.00 per yr.)	$200,000 per person. $600,000 in any one policy year.
Registered Nurses Association of Nova Scotia	No	No	
Association of Nurses of Prince Edward Island	No	No	
Association of Registered Nurses of Newfoundland	Yes	Yes	$100,000 per incident with $200,000 aggregate.
Northwest Territories Registered Nurses Association	Yes	Yes	$500,000 in any one policy year.

Source: Directors, provincial/territorial CNA member associations.

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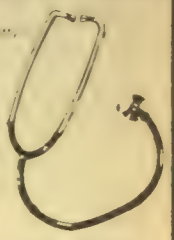
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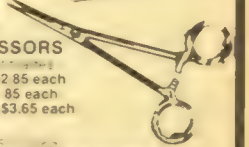
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Applications are invited for the position of Associate Executive Director, Canadian Nurses Association, Ottawa.

Candidates must be members of the Canadian Nurses Association, have a master's degree or equivalent and have at least five years' administrative experience. Bilingualism an asset.

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Ref. No: 77-PSTP-22-102 (N)

Duties
The candidate directs, administrates and evaluates the nursing service and nursing education program in the Regional Psychiatric Centre; develops the aims, objectives, orientation and in-service programs for the nursing service; and prepares the budget, establishes nursing procedures and work performance requirements for the Centre.

Qualifications
The successful candidate must possess a Bachelor's Degree in Nursing and registration as a registered nurse in a province or territory of Canada. Experience and demonstrated competence in nursing service management are required. Knowledge of English is essential.

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Ref. No: 77-PSTP-22-103 ( )

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Further information may be obtained from M. Caroll, Director, Nursing Operations, Canadian Penitentiary Service, 340 Laurier Avenue West, Ottawa, Ontario K1A OP9

How to Apply
Forward completed "Application for Employment" (Form PSC 367-4110) available at Post Offices, Canada Manpower Centres or offices of the Public Service Commission of Canada, to :

Professional, Scientific and Technical Program
Public Service Commission of Canada
300 Laurier Avenue West
Ottawa, Ontario K1A OM7

Closing Date: June 30, 1977

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Interested candidates are required to have the managerial ability to work with all levels of nursing, administration and medical staff.

MINIMUM QUALIFICATIONS:
Must be currently registered in the Province of Ontario. Preference will be given to candidates with additional educational preparation and experience in nursing management.

Resumes should be sent to:

Mr. R. E. Capstick
Manager, Employment & Staff Relations
McMaster University Medical Centre
1200 Main Street West
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Comp. No.: 77-V-CPS-88

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Miss F. Tomlinson
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Sudbury & District Health Unit
1300 Paris Crescent
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Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

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For additional information please contact:
Phyllis Peters, Regional Nursing Officer
Canadian Penitentiary Service
Regional Headquarters, Prairies
P.O. Box 9223
Saskatoon, Saskatchewan S7K 3X5

Telephone: (306) 665-4871

How to Apply
Forward completed "Application for Employment" (Form PSC 367-4110) available at Post Offices, Canada Manpower Centres or offices of the Public Service Commission of Canada, to:

Public Service Commission of Canada
500 Credit Foncier Building
286 Smith Street
Winnipeg, Manitoba R3C OK6

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Apply in writing to:

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Belleville General Hospital
Belleville, Ontario
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The Canadian Nurse

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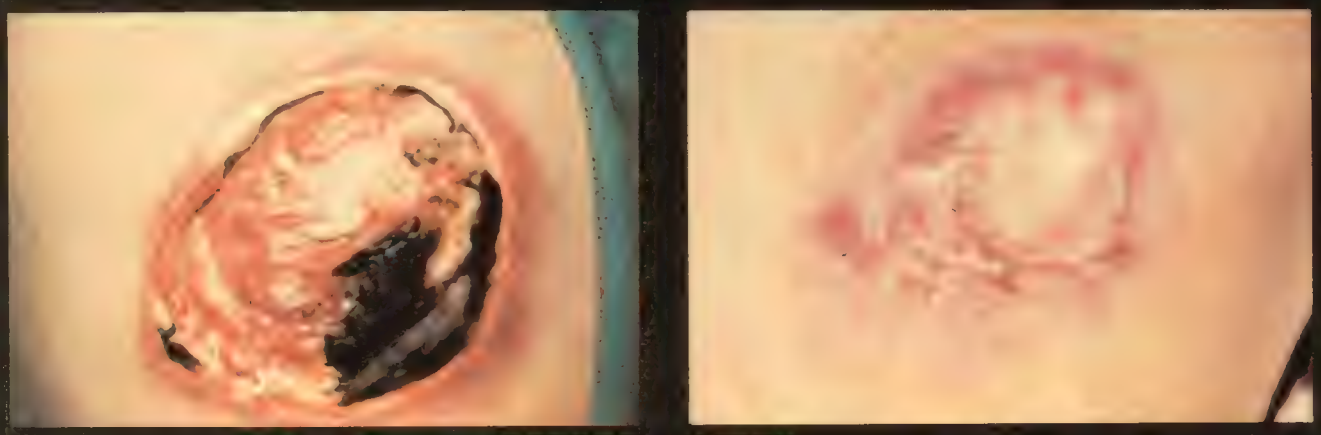
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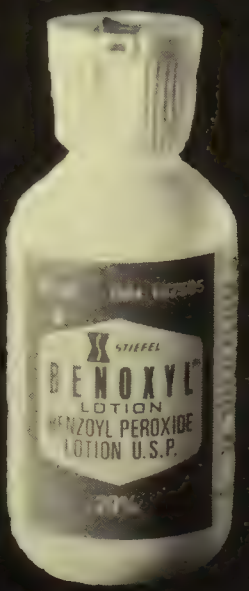


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the canadian nurse

July 1977

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the canadian nurse

July, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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It was 1892 when Canadian poet Archibald Lampman called summer a time "for loafing and dreaming and getting close to nature." Things haven't really changed — every summer, Canadians are "getting away from it all," enjoying camping, relaxing at cottages, swimming, and long lazy walks along the seashore. This month's cover photo, courtesy of Health and Welfare Canada captures a little of the spirit of summer.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

ISSN 0008-4581

Indexed in International Nursing Index, Cumulative Index to Nursing Literature, Abstracts of Hospital Management Studies, Hospital Literature Index, Hospital Abstracts, Index Medicus. *The Canadian Nurse* is available in microform from Xerox University Microfilms, Ann Arbor, Michigan, 48106.

The Canadian Nurse welcomes suggestions for articles or unsolicited manuscripts. Authors may submit finished articles or a summary of the proposed content. Manuscripts should be typed double-space. Send original and carbon. All articles must be submitted for the exclusive use of *The Canadian Nurse*. A biographical statement and return address should accompany all manuscripts.

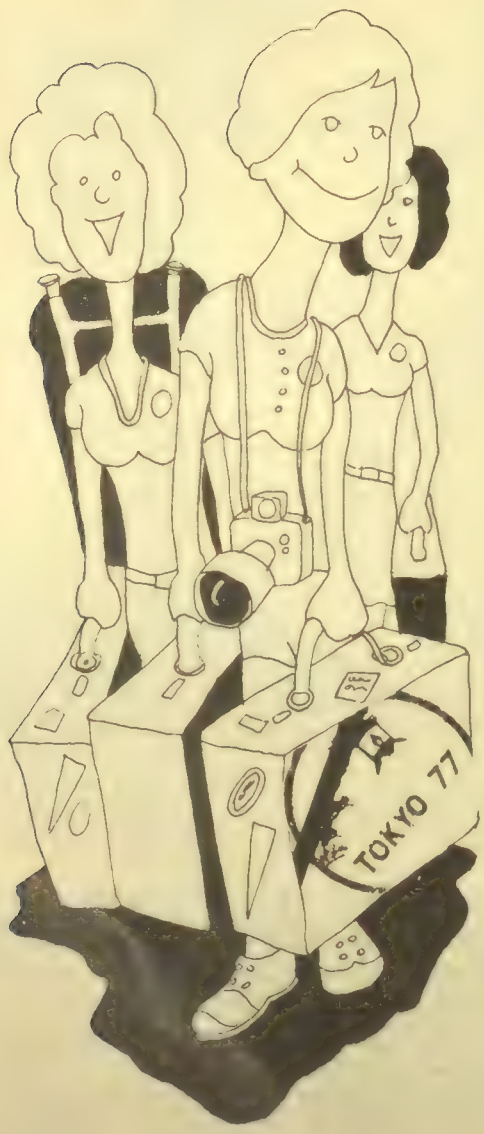
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Canadian Nurses Association, 50 The Driveway, Ottawa, Canada, K2P 1E2.

Perspective



A fortunate few Canadian nurses spent the first week of June in Tokyo, Japan, rubbing shoulders and exchanging ideas with their professional counterparts from close to 100 countries around the world. The occasion was the 16th quadrennial congress of the International Council of Nurses, an event that attracted more than 12,000 nurses, including approximately 530 Canadians.

For both participants and observers, the congress provided a unique learning situation — a never-to-be-forgotten opportunity to acquire firsthand information about nursing practice, education and professional responsibility on a world-wide scale.

International nursing became a living reality for these nurses. But what about those of you who stayed at home to cope with the day-to-day responsibilities of looking after the health of this country's population?

Did you know that you also support nursing at the international level through membership in your provincial association?

Did you know that your fellow ICN members number close to a million nurses around the world and that the Council exists to serve all nurses, regardless of nationality, race, creed, color, politics, sex or social status?

Did you know that the ICN which was founded in 1899 is recognized as the oldest international professional organization in the health field?

Did you know that the ICN exists to provide a vehicle for nursing associations throughout the world to share common interests and work together to develop the contribution of nursing to the promotion of health and care of the sick around the world?

Did you know the ICN has adopted official policy statements on issues such as human rights, family planning, equal pay for equal work and continuing education? And that the ICN has formulated a Code for Nurses recognized by nurses internationally?

So, whether you were in Tokyo or not, the ICN is YOUR association. It exists to help you and to help you help other nurses throughout the world.

— M.A.H.

Herein

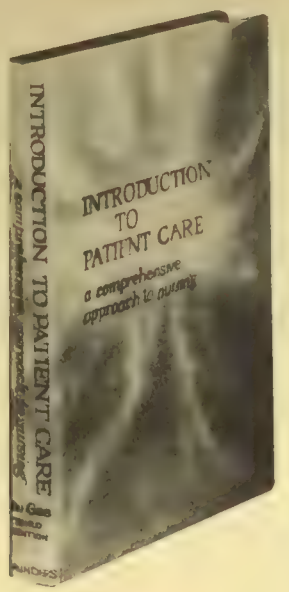
There are approximately 8,000,000 children in Canada today. Recently the Canadian Institute of Child Health began operation in Ottawa. The purpose of the Institute is to take a look at the special problems facing children in our modern society—problems like immunizations, nutrition, poverty, venereal disease and physical fitness.

The Institute hopes to act as a catalyst to encourage people all across the country to think about, and work towards, improving the mental and physical health of our children. How can we as nurses help?

This month CNJ talked to Shirley Post, a nurse who believes the question of child health has to be taken on as a personal responsibility

How long has it been since you updated your knowledge about the care of the burn patient? Too long? **Next month,** in a series of three articles, CNJ takes a look at the basics of burn care — the principles of first aid, the priorities in treatment, drugs and nursing care. Dietician-nutritionist Rosemarie Repa Fortier reviews the nutritional needs of the burn patient and author Marilyn Savedra investigates strategies of helping the severely burned child cope with pain.

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Planning and health care

Ever since my copies of *The Canadian Nurse* began arriving in Barbados a few months ago, I have noted with concern the repeated reports of a depressed market situation for nurses in Canada, and the numerous pleas for improved methods of long-term nursing manpower planning.

As a former director of the now non-existent Health Manpower Directorate of Health and Welfare Canada, I would like to point out that early warning signs of the present over-supply of nurses were evident as far back as six years ago. National projections of anticipated supply and demand for nurses, made in 1971 for the forthcoming 10-year period, clearly indicated that we were tending towards an over-production of graduates from our diploma schools of nursing.

A report prepared by our division in December 1971 warned that, unless the situation changed drastically in the next few years, "we must be prepared for an unemployment problem with nurses."

Immediately after the report was prepared, it was taken to a meeting of the CNA board of directors to alert them to the results of our projections. The report was also circulated to all provincial nursing associations and to all provincial governments with the recommendation that, because the situation might well vary in different provinces, nursing manpower studies should be undertaken at the provincial level without delay. Outcomes of the report included the establishment within a few months of a National Committee on Nursing Manpower and the provision of assistance by the division to two provinces (on their request) with studies of their nursing needs and resources.

Ontario and a number of other provinces undertook their own studies and, as I recall, the Ontario short-term projections of nursing supply and demand were remarkably accurate. As has been noted elsewhere, it was unfortunate that they did not appear to believe their own long-range forecasts.

The problem of improving nursing manpower planning would appear to lie, then, not so much with better methods of forecasting — we were warned by our earlier projections — but, rather, with the rational coordination of health services planning and that of educational authorities to prepare the required number of nurses and level of practitioner and to ensure their most effective utilization in our health services.

Nursing is the largest component of Canadian health services. It is essential, therefore, that nurses be involved in all aspects of planning for health care if the profession is to react appropriately and in time to achieve a more stable balance between the supply of nurses on the one hand and demand for their services on the other.
— Beverly Witter Du Gas, R.N., Ed. D., PAHO/WHO Health Sciences, Barbados.

P.S. I like the new format of the journal, and look forward to receiving my copy each month.

Sharing budget restraints

I would like to commend Thelma Miller on her excellent letter to the B.C. Minister of Health, a letter that also appeared in *The Canadian Nurse*, April 1977.

I work in a hospital in Montreal. As a head nurse I feel just as frustrated trying to run a good floor with a high standard of nursing care. Due to reasons similar to those Mrs. Miller states, quality care is becoming almost a myth. We are constantly reminded to "budget," to cut down on supplies, cut down on nurses, cut down on overtime; but a good nurse is a good nurse, and she or he will strive for the impossible, regardless of restraints imposed.

Our hospital is a teaching hospital and there seems to be no restraint or budget on what the medical staff, interns, and students can order in the name of medicine. Blood tests, x-rays, procedures, etc. are ordered regardless of cost, and in many cases, regardless of the fact that the patient has had these procedures done before, or that they are old people who would like to be treated as people — with a little T.L.C. These procedures increase the workload of the nurses who are overloaded with extra work — all in the name of medicine.

A letter should be sent out to all concerned, including the public to let them know 'why mother fell out of bed,' or 'why grandpa's lunch was late,' or 'why great-grandpa was resuscitated for the third time.' I'm sure every nurse in every department has the same problems. I'm not knocking the medical teaching program, but if we have to budget and cut short on our care, the others should be asked to share in cutting costs.
— Ira Sen, R.N., Montreal, Quebec.

Surnames again ...

Just a quick note to express an opinion. I feel strongly that the use of Miss and Mrs. must be avoided to effect an end to discrimination on the basis of marital status. Titles indicating position or academic degree are fine.

I really do not care much whether people call me by my first or last name. However, in communication between strangers, which is what a journal involves, a little formality does not seem inappropriate. It is very common when speaking or writing about authors to use their last names. I do not find the practice "harsh," "abrasive" or "pretentious." What is pretentious about being business-like? Are we adults and professionals or school children?
— Nora J. Briant, R.N., Fredericton, New Brunswick.

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And on all will fall a hex
Who try to rob me of my sex.
—Mr. *David J. Davis, R.N., R.P.N., Burnaby, B.C.*

A note of appreciation

Kudos for the April issue of *The Canadian Nurse.* I work as a permanent night charge nurse in a nursing home, and I found the articles in the April issue interesting and very informative.

I believe that some of my colleagues feel that it is boring and uninspiring to work in a nursing home ... but I firmly believe that the articles in the journal may help nurses to realize that there's a lot to being a 'nursing home nurse.' Working with and caring for older people has helped me to have a better perspective on aging.

I hope to read more articles about geriatric nursing in future issues of *The Canadian Nurse.* I also wish to express sincere appreciation to all the contributing authors to the April issue.
— Myndah Derro, R.N., B.S.N., The Pas, Manitoba.

Avoid inhaling

Recently, I learned of a small hospital which had got rid of its cigarette vending machines. When the hospital administrators realized that they were losing the profits from these sales, they re-installed them!

This is typical of our confused thinking. Hospitals have notices banning smoking in corridors and elevators but the public may smoke in lounges, and most of the nursing personnel smoke in the dining room.

To a layman such as myself it is paradoxical that nurses — and doctors — should themselves persist in a habit that is "harmful."

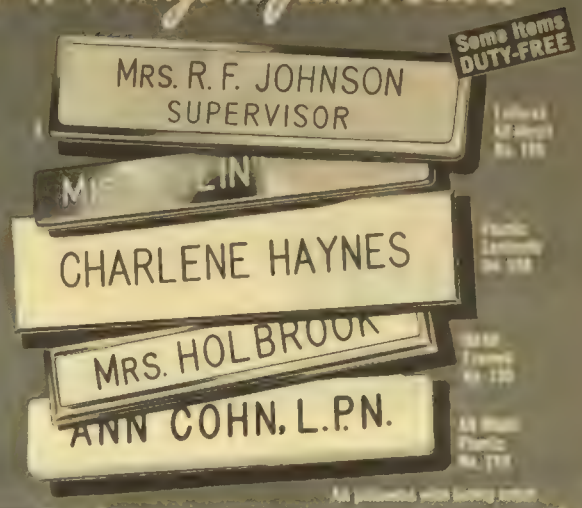
One nurse who deals exclusively with patients suffering from respiratory diseases, and who herself smokes two packages of cigarettes a day, says, "I wish the hospital rules would prohibit all smoking here."

A volunteer group in a Toronto hospital has been trying to have cigarette sales banned in the gift shop, but without success: they cannot defeat the argument "We would lose revenue if we ban cigarettes."

Perhaps one day the Medical Council will ask the government to add to the existing warning on cigarette packets the following seven words: "KEEP IN TOUCH WITH YOUR LUNG SPECIALIST."
— Eric Curwain, Etobicoke, Ontario.

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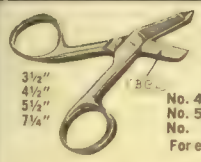
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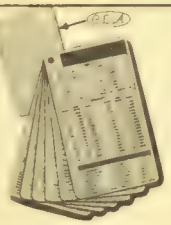
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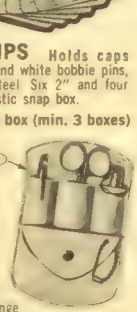
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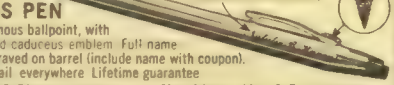
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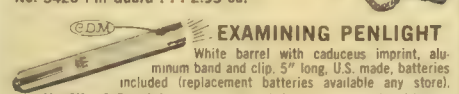
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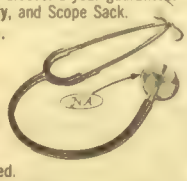
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Input

Help or hindrance?

I must disagree with Hodnett's conclusion *(Fetal Monitoring, Why Bother? March, 1977)* that fetal monitoring should be routine for all women giving birth. A recent study seriously questions whether fetal monitors *do* lower perinatal mortality and morbidity any more than conscientious nursing care does ("The Evaluation of Continuous Fetal Heart Rate Monitoring in High Risk Pregnancy," Haverkamp, A., et al., *Am. J. Obstet. Gynecol.*, June 1, 1976).

The authors became involved in this research because, although numerous statements have been made by leading obstetric authorities that all labors should have electronic fetal monitoring, no controlled study has been done to evaluate the actual influence it has on perinatal death and morbidity.

A total of 483 high risk patients were fitted with scalp electrodes and uterine catheters so both fetal heart tones and uterine contractions could be evaluated. The monitor was used with half of the sample and with the other half the bedside monitor was shut off and the monitor in the hall covered. These women had their fetal heart tones auscultated by a nurse every 15 minutes in first stage of labor, and every five minutes in the second stage.

In the monitored group, fetal distress was defined by the criteria of Hon and Kubli. In the auscultated group fetal distress was diagnosed when fetal heart tones dropped below 100 beats per minute after three or more consecutive contractions despite any corrective measures. *There were essentially no differences in the perinatal mortality and morbidity of the two groups.* The difference between the number of infants requiring intermittent positive pressure ventilation at two minutes (2.1% for the monitored group and 0% for the auscultated group) was of borderline significance with a P value of < 0.07.

In the machine monitored group 40 women (16.5%) gave birth by cesarian section, while only 16 (6.6%) of the nurse monitored group had cesarian section deliveries. The rate of postpartum infection was also significantly higher in the monitored group, 13.2% compared to 3.4% in the nurse monitored group. Even with correction for cesarian section the rate was statistically significant. This difference was unexplained.

Haverkamp et al theorized that the nurse, with her physical and emotional support throughout labor, had a beneficial impact on mother and baby. They also hypothesized that the machine was an irritating factor with its flashing lights, audible sound for the fetal heartbeat and visible patterns on the screen.

I note that in the photographs in Hodnett's article the women are lying on their back, unfortunately a requirement of most women being monitored indirectly. However, it is well documented that prolonged back lying during labor and delivery can result in fetal hypoxia.

In view of the points raised I think we must seriously question the routine use of fetal monitors. In selected cases, electronic fetal monitoring is a very valuable adjunct in our assessment of mother and baby, *but* I feel we must deal with the very real possibility that the presence of the fetal monitor itself may be a disturbance to the normal process of labor and birth resulting in a higher incidence of fetal distress, and consequently more cesarian births.
— Elaine Carty, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

Abortion counselling no solution

The Badgely Report states that "a large proportion (84.8%) of the women who were seeking an induced abortion were contraceptively experienced, and it was factors other than their lack of knowledge or exposure to contraceptives that were involved in accounting for their unwanted pregnancies " (p. 381).

In light of this evidence it is clear that Mr. Lalonde's program of actively promoting family planning will not effectively curtail the escalating number of abortions. Lack of motivation to prevent unwanted pregnancies would appear to be the cause of ineffectiveness of family planning programs.

As long as abortion counselling services are readily available, no amount of family planning promotion will make the program effective.
— M. Case, Prince Albert, Sask.
Editor's Note: *See CNJ May, 1977, p. 16, "News".*

Call for change

The February edition of *Pediatric Clinics of North America 1977* provides a shocking eye opener for nurses. Ignorance has led us to defeat our objective of health promotion. We have in fact been fostering the occurrence of disease by playing a major role in the promotion of formula feeding. It is our professional responsibility to update our knowledge.

Prominent authorities in the field of infant nutrition assert that promotion of breast-feeding should be looked upon as a major public health measure. Not only would its reintroduction as the dominant method of feeding eliminate formula induced hazards, but new knowledge shows that breast milk will provide protection against disease later in life as well as during infancy.

The impact of this issue does not remain at the individual level. Its ramifications extend into the health and economics of society and the world at large. We are paying dearly by artificially feeding our young and the only profit to be found is in the purses of the food industry.

Health professionals must take stock of their attitudes and review their current perinatal practices. Nurses have much to evaluate, much to change. The position as leader in this field of preventive practice is up for grabs and our responsibilities are clear. We must take immediate steps to correct this almightly blunder that has been committed by our technological age.
— Pat Phillips, R.N., Fairview, P.E.I.

On cardiac depressants

I have just finished reading the May issue of *The Canadian Nurse*, and wanted to express my appreciation for Eleanore Warkentin's article "Programmed Learning — Cardiac Depressants." This article proved to be a most valuable review. I hope that in the future you will publish more articles of this nature.
— Luci Golab, R.N., Thornhill, Ontario.

Did you know ...

The Vancouver Perinatal Health Project or "Parent's Choice" is one attempt to integrate services for expectant families. It is conducted cooperatively by the Vancouver Health Department and St. Paul's Hospital — Departments of Obstetrics, Gynecology, and Family Practice — without disrupting the traditional doctor-patient relationship. At the beginning of her pregnancy, a woman is referred to the program by her doctor. The program staff follow the family for up to six months post-partum, providing nutritional assessments, prenatal classes, food supplementation, and individual counselling as necessary.

A second project, known as "Healthiest Babies Possible" runs concurrently. It focuses on nutritional assessments and education for pregnant women who choose not to attend prenatal classes due to attitude differences or language barriers. Trained lay health workers and project staff provide these services in the woman's home in several languages, including Chinese, Italian and Greek.

Both projects have been funded by the City of Vancouver and the Government of British Columbia for a two-year period.

News

Future for VON despite budget cuts

The transfer of home care services to government-administered programs and increased budget restraints emerged as the two key problems facing the VON for Canada at their 79th Annual Meeting in Ottawa early in May. Yet in spite of these problems, National Director Ada McEwen was optimistic about the future of visiting nursing services, citing the 13% increase in government support of VON home visits in the last six years as indicative of the importance of this aspect of health services. In her Annual Report to the meeting she added, "in spite of restraints on spending, the trend to more government financing of this basic service in all provinces is essential if care in the home is to be a viable alternative to other more expensive levels of care."

This increased interest in home nursing has resulted in various changes in administration, however, as some governments move towards a provincial approach to provision of home care programs. During 1976 the staff of the VON in B.C. worked closely with provincial health personnel to prepare for a transfer of service to municipal authorities in the Vancouver area. Some VON branches in Quebec were also affected in a move to provide home care services through community health departments of hospitals and community health clinics. In Calgary and Edmonton, the administration of home care programs has been transferred to health departments, although VON branches continue to provide nursing care in their areas.

These changes have had an effect on the statistics of the organization. McEwen indicated that half of the 10% decrease in the number of patients visited by the VON and the 6% decrease in the number of home visits from 1975 to 1976, could be attributed to this transfer of services. The remainder was a result of budget restraints.

To the degree that budget restraints forced a re-evaluation of the efficiency of services, they had a positive effect, she said. In some areas more attention was given to teaching family and friends to care for the ill, and in others the use of volunteers as support was explored. But she added that, as well as reviewing the efficiency of their programs, "we must be prepared to object strongly, as some branches did, to arbitrary budget restraints that deprive individuals of essential services at home and, not infrequently, result in admissions to more expensive care facilities."

She cited another negative effect of budget restraints as the decrease in the number of branches involved in occupational health counselling, from 24 in 1972 to 18 in 1976. Most companies that discontinued this service apparently gave budget restraints as the reason. Yet statistics indicate a steady increase in the number of patients with circulatory and heart conditions, and occupational health is receiving high priority in federal and provincial governments. McEwen concluded that "Health counselling services in industry allow contact with individuals between 25 and 65 years of age and could contribute to healthier life-styles with a potential reduction in chronic illnesses in later life."

On the brighter side, McEwen noted that the VON continues to concentrate services on meeting the needs of medical and surgical patients, and that care of the elderly is receiving high priority in all branches.

With the increasing number of elderly in our society, more attention is being given to improved ways of helping them cope with their unique problems. She pointed out that, while 75% of the elderly have some form of chronic illness, most are not severely limited by their conditions and over 90% are at home. She noted that an effort is being made by government to reverse the trend of building institutions for the aged by re-allocating resources.

McEwen added that, "the growing list of VON branches, 25 in 1976 compared to 12 in 1974, providing counselling services in senior citizen residences, both large and small, is indicative of the interest and effort in helping these individuals to remain healthy and independent as long as they can."

Other VON services that allow the elderly to retain their independence include Meals on Wheels. But, she added, "Appropriate housing and transportation services, improved and expanded support services including homemaker and home help services, meals on wheels, friendly visitors will be necessary to allow individuals to make the choice of remaining at home."



One hundred and fifty member-states, including almost every country of the world, took part in the recent Thirtieth World Health Assembly in Geneva, Switzerland. Discussion during the 21-day meeting, centered on the Assembly's target of health for all the citizens of the world by the year 2000.

Above, some members of the Canadian delegation are photographed during the meeting. Left to right in the front row are: Aubert Ouellet, deputy minister of social affairs, Quebec; Helen K. Mussallem, CNA executive director; Dr. A.J. De Villiers, director general, International Health Services, Health and Welfare Canada; R. Harry Jay, ambassador and permanent representative, Permanent Mission of Canada to the United Nations Office and International Organizations at Geneva.

News

SRNA Diamond Jubilee celebrates sixty years of growth and progress

This year's May Annual Meeting of the Saskatchewan Registered Nurses Association gave delegates an opportunity to pause and take a close look at the past, present and future of the nursing profession in Saskatchewan and in Canada. CNA president **Joan Gilchrist,** director of the School of Nursing at McGill University, Montreal, brought greetings from CNA to the association membership.

In her opening remarks to over 400 nurses present, SRNA president **Sheila Belton** referred to the dramatic changes in nursing over the Association's 60 years, changes that will continue in the future. "Each individual," she said, "has a responsibility to determine what changes should be made and the directions that nursing must take. We must be involved in decision-making concerning the delivery of health care services ... specifically those decisions being made related to the future of the nursing profession and the provision of nursing care."

The lively response of delegates to the Council's proposed revision of the Saskatchewan Registered Nurses Act and Bylaws and to the resolutions presented was perhaps an indication that both new and long-standing members of the Association are committed to involvement and planning for change. Many of the 24 resolutions passed by the assembly were concerned with strengthening the voice of the provincial Association on a variety of broad health care issues. Collective approval was given to:

- requesting the appointment of an SRNA member to provincial government interdisciplinary health care committees
- the continual promotion of the acceptance by the provincial government of the principle of funding health care agencies for orientation and staff development programs until such funding is an accomplished fact
- requesting the Departments of Health and Social Services to cooperate in an effort to eliminate duplication, fragmentation, lack of continuity and increased cost of services in the delivery of health care
- bringing the need for increased supervision of prescribed drug therapy in the home and the necessity for this service to the attention of the Minister of Health
- requesting the Government to review the entire system for extended care in Saskatchewan to bring about an orderly, coordinated, well-defined and more equitable system
- seeking direct SRNA representation on planning and action committees being established as a result of the Government report "Adding Life to Years" by Dr. S.L. Skoll
- recommending to the Minister of Health a comprehensive parent-child education television series developed with emphasis on basic child health care and prevention of unnecessary hospitalization
- making a collective and concerted effort towards further membership involvement in Association business through support of Association activities
- responding promptly and publicly as an Association to issues directly influencing nurses in their functions of providing quality health services to Saskatchewan consumers
- strongly recommending to the government of Saskatchewan that home care programs remain under the jurisdiction of the Regional Health Services Branch of the Department of Health
- lobbying for a public education program to be sponsored by the government on the use and misuse of prescription drugs.

In addition, delegates agreed that the SRNA Council:

- support research into the effects of ratio of staff to patient workload, staffing and rotation patterns on the quality of nursing care
- publicly affirm the belief that one of the accepted rights of the individual is to choose to die with dignity, in comfort, without extraordinary means of life support
- pursue mechanisms through the provincial institutes of applied arts and sciences and the University of Saskatchewan to establish educational programs in gerontological nursing in Saskatchewan
- request financial assistance from the Department of Health for Continuing Nursing Education through the College of Nursing, University of Saskatchewan and support the request of Continuing Nursing Education for additional funding from voluntary agencies.

The final draft of the proposed changes to the SRNA Act and Bylaws was presented by the Committee on Legislation and Bylaws to membership: the draft was discussed and approved in principle for review by the Saskatchewan legislature. Membership also approved an increase in SRNA registration fees to $75 per year.

Delegates learned that the Saskatchewan Hospital Services Plan will be providing funds this year for a one month orientation program for new graduates in hospitals of 50 beds or less, a move pushed by SRNA in meetings with government representatives, and most recently through the survey "Performance Expectations of Beginning Graduates" (see page 12) which was made available to the government in January 1977. President Sheila Belton assured the membership that they would continue to press for orientation programs for all new nurse employees in *all* hospitals.

Norma J. Fulton, director of Continuing Nursing Education, a program of the College of Nursing, University of Saskatchewan, Saskatoon, reported on the increasing number and support of workshops provided throughout the province during the past year. The program is partly funded by SRNA.

Newly elected members to SRNA Council were: First Vice-President— **Della Howe,** program supervisor, diploma nursing, Wascana Institute of Applied Arts and Sciences; Chairman of the Committee on Chapters and Public Relations — **Phyllis Goertz,** head nurse on a medical unit at the University Hospital, Saskatoon; Chairman of the Committee on Social and Economic Welfare — **Pearl Folkerson,** head nurse on a medical ward, Battlefords Union Hospital, North Battleford.

Two panel presentations provided delegates to the three-day meeting with the opportunity to take a look at where nursing is going. The first, entitled "Nursing — Past-Present-Future", was moderated by **Madge McKillop,** a former president of SRNA and assistant executive director of University Hospital in Saskatoon.

Louise Miner, director of Public Health Nursing for the Saskatchewan Department of Health and a former president of SRNA and the Canadian Nurses Association, talked about the growth of public health nursing in Saskatchewan and urged the expansion of preventive health programs for children, emphasizing the need for interpretation of preventive medicine to the public. **Pearl Folkerson,** president of the Battlefords Chapter SRNA and vice-president of Saskatchewan Union of Nurses local, spoke about the trend towards specialized nursing, stressing the importance of geriatrics as the specialty of the future. **Marilyn Reddy,** a regional representative of S.U.N. and member of the Regina General Hospital's Committee on Alcoholism reviewed the change in nursing education from obedient apprenticeship to an education-centered program. **Hester Kernen,** dean of nursing of the University of Saskatchewan emphasized the importance of taking responsibility for change in nursing, reevaluating priorities, and teaching effectively through example. **Pat McGrath,** a former president of SRNA and the Canadian Catholic Hospital Association and presently Hospital Standards Consultant in Nursing for Saskatchewan Hospital Services Plan stressed the importance of health teaching and primary care in nursing.

A second panel presentation 'Health Care — Quality at What Cost?' took a comprehensive look at a provocative and timely issue. Panel members taking part in the fast flowing and controversial discussion included:

Mel Derrick, deputy minister of Health in Saskatchewan, **Dr. E.F. Busse,** president of the Saskatchewan Medical Association, **Richard Fontanie,** assistant deputy minister — Community Affairs, Saskatchewan Department of Social Services, **Maria Reardon,** director of education for Saskatchewan Health Care Association, and **Jean Conroy,** assistant professor of Nursing, University of Saskatchewan and former SRNA president. Saskatchewan journalist and radio announcer, **S. Shragge,** moderator for the panel, summed up the contributions of panel members in the following suggestions for maintaining quality care at less cost: by changing life-styles, ending defensive practice that brings about costly duplication of services, setting a high priority on patient teaching, and using an interdisciplinary approach in which nurses, doctors and the government participate responsively and cooperatively.

Huguette Labelle, director general, Policy, Research and Evaluation Branch of the Indian and Eskimo Affairs Program, past CNA president and former Principal Nursing Officer for Health and Welfare Canada, was guest speaker for the Diamond Jubilee Meeting. She left delegates with a look towards the future, and changes that they as individuals and as an Association have the responsibility to shape. Labelle stressed the importance of looking at where we are now in the world around us, taking the responsibility for keeping in tune, getting into planning and making sure that changes are for the best. She stressed the importance of recognizing certain indicators for the future: at the evolving acute care system, the rising importance of occupational health, decreasing size of families, limitations in the health care budget, the increased trend towards deinstitutionalization, conservation values and the demystification of medicine. Recognizing these trends, she suggested weighing the nurse's influence in schools and communities, in planning committees.

Labelle said that given knowledge about trends, nurses must aim at a community support system, a "community for coping . ... where we are not doing for ... but facilitating ways in which people can do for themselves." She underlined the need for careful planning, so that nurses can use creative, imaginative minds to make 'hard decisions' towards the health of people.

Retired nurses aid elderly in Alberta

New horizons in health care are being met by a group of retired nurses in Edmonton, Alberta. The Strathcona Retired Nurse Services began when volunteer retired nurses recognized the need for supportive care for many senior citizens.

The aim of the volunteers has been to reach people who are living in isolated or uninvolved retirement. These people may be physically unable to participate in other planned programs, and the volunteers have found them to be lonely — craving social contacts.

Together the nurses have many years of experience in various health care fields. They are not employable — but they are well qualified to cooperate with and guide a group of men and women volunteers who, like them, feel the need to be of service to others in their community.

By noting the physical abilities, social needs and special interests of the person, the volunteers have helped to make changes in life-style after illness or injury, less traumatic. The volunteers try to provide the elderly with helpful aids to daily living, tempered with a good measure of reassuring support.

One of the volunteers says, "We have found many timid folk who have difficulty in communicating with relatives and friends, they need support. They are often unable to interpret directions from their physician. They are unaware of the agencies in the community which offer special services for senior citizens. Their problems can often be identified during a friendly visit and referred to the appropriate agencies."

On the other hand people have been referred to the Nurse Services group by the V.O.N., the Public Health Department, the Department of Social Services and Community Health, Mental Health Services, physicians, hospital social workers, the Edmonton Home Care program and many concerned individuals.



"Coping with Loss," a one-day seminar sponsored by the Faculty of Nursing, University of Toronto in cooperation with the Registered Nurses Association of Ontario attracted approximately 70 nurses from in and around the Toronto area in early May. Shown above are some members of the Course Advisory Committee who planned the successful education day. From left to right are: Eleanor Trutwin, Nursing Division, RNAO; Mary K. Harrison, Assistant Professor, Faculty of Nursing, U. of T.; Hilda Mertz, Associate Professor, Faculty of Nursing, U.of T.; Nancy Chadwick, Nursing Division, RNAO; Dorothy Brooks, Chairman, Continuing Education Program, Faculty of Nursing, U. of T.

Helen Sabin named AARN honorary member

The Alberta Association of Registered Nurses has honored its retiring executive director, Helen Sabin, with an honorary membership in the association and establishment of an educational scholarship in her name.

AARN president Audrey Thompson presented the honorary membership to Sabin during the association's annual meeting in May. The scholarship, in the amount of $2,000, will be awarded to members wishing to pursue graduate studies of not less than one academic year in the final year of a baccalaureate program or in a master's or doctoral program.

Sabin's abilities were recognized by the national association when she was chosen to represent the Canadian Nurses Association at the 1970 International Council of Nurses' Seminar on Legislation in Warsaw, Poland. Her expertise was also sought by the nurses of the Northwest Territories in their successful endeavors to found the Northwest Territories Registered Nurses' Association in 1974.

In 1976, Sabin was the recipient of the Alberta Achievement Award in the Service Award Category for outstanding service to her profession.

Sabin was executive director of the AARN from 1960 to March, 1977. Her professional career as a registered nurse in the province of Alberta spans the period from 1938 to 1977. During her term as executive director, she was responsible for the implementation of policy as directed by the Provincial Council and for co-ordinating activities that included speaking for nursing, interpreting association policy and seeking solutions to mutual concerns with members, governments and associations.

News

Manitoba nurses study implications of development of nursing standards

What part does the development of standards for nursing practice play in assuring competence, accountability, responsibility and excellence in nursing? This year's May Annual Meeting of the Manitoba Association of Registered Nurses gave over 250 MARN delegates the opportunity to take a close look at the implications written standards have in providing nurses with the direction necessary to allow them to use their own judgement and creativity in many clinical settings and ensure quality care to the consumer.

The past year has seen MARN deeply involved in the development of nursing standards; workshops in the nursing process have been held throughout the province to promote the framework within which nursing practice standards have been developed. The Standards of Care Subcommittee of MARN's Nursing Committee has used questionnaires to involve membership and consumers in the development of draft standards.

The establishment of these standards has grown out of a resolution passed at last year's Annual Meeting. This year, delegates gave further support to standards by resolving:

- the acceptance of the broad Standards of Nursing Practice so that they may be implemented and evaluated
- that each nurse take personal responsibility to prepare herself/himself to consider the application of MARN's broad standards for daily nursing activities
- that MARN's Board of Directors continue to encourage employers to support the use of the nursing process by individual nurses.

What part do nursing standards play in quality assurance? Keynote speaker **Joan Ganong,** vice-president and nurse consultant with the W.L. Ganong Company, Consultants to Management, Pittsburgh, Pa., pointed out that nursing with its focus on results, needs standards to enable effective evaluation, for measurement of quality against "something solid, not ephemeral." Ganong, who has many nursing publications to her credit as well as experience in both nursing education and service, differentiated between the workload concept of nursing, based on tasks, procedures and routines that are "going nowhere ... and killing professional nursing ..." and the new patient care management concept. The latter involves asking ourselves: "Are the patient's needs being identified, are they being met based on nursing process rather than routines?" Ganong stated that most nurses are "in the middle ... trying to learn new ways."

The speaker also said that in order to judge quality, nurses need to create a plan, take action by implementing the plan, and evaluate the results of their plan and action. In this way, nurses can ensure that they are accountable for their nursing care. Ganong stressed the importance of "academic excellence with the patient in mind, ... of progress for us meaning progress for the consumer." She also underlined the fact that quality of care stems from quality of the nurse herself, that standards derive greatly from personal experience. "Quality begins with the individual in any institution ... with self-knowledge, increased knowledge and skills, tempered with caring for others." Within the framework of standards developed by the profession, Ganong said "we can use our judgment and feel good about it" by seeing results, by being able to evaluate our efforts in a measurable way.

A panel presentation moderated by **Margaret McCrady,** director of educational services, nursing, at Health Sciences Centre, Winnipeg and 2nd vice-president of MARN for the past two years, saw MARN members from various areas of nursing discuss the implications of standards to their particular settings. Included in the panel were: **Dr. Gaetane Laroque** vice-president, patient care, Health Sciences Centre — representing nursing administration; **Lesley Degner,** associate professor and research associate, School of Nursing, the University of Manitoba — representing nursing research; **Joanne Oldham,** home care nurse for the public health department — representing nurse practitioners in public health; **Belle Gowriluk,** nurse clinician, medicine, Misericordia Hospital — representing nurse practitioners in the institutional setting; **Shirley Jo Paine,** director of nursing education, Brandon General Hospital School of Nursing — representing nursing education.

It was brought out by the panel that written standards would imply consistent nursing decisions in favor of the client and would enable nurses to defend a systematic and rational approach to care. It was said that nursing research has a role in quality assurance through finding, demonstrating and evaluating models of practice. Standards as guidelines were seen as a way of facilitating staff rapport and the growth of nurses, as a way to meet the goals of consumer protection and care. They were also seen as an impetus to encourage responsibility, accountability and creativity. It was suggested that teaching would be made easier by using written standards, and that standards would allow the young graduate to know what is expected of her.

Roundtable discussions following the panel presentation gave everyone present the opportunity to voice questions and concerns about standards in small group settings led by panel members and members of the subcommittee on standards. Following these lively discussions, C.N.A. president **Joan Gilchrist** summarized some of the feelings and concerns expressed by participants. She remarked that generally, the tone of discussions was positive in nature — that standards were seen as valuable in assuring accountability, responsibility, quality care, and the rights of the consumer. Gilchrist also outlined the concerns voiced by nurses around the discussion tables; a concern that the meaning of nursing process, assessment and nursing diagnosis must be made clear; the concern that nursing care plans could become just another ritual; the concern that the use of new words and a different vocabulary could cause an interference in communication among nurses; would standards, in fact, improve the quality of our care?

Joan Gilchrist also said that it was necessary for those who developed nursing standards in Canada to share with other areas and prevent duplication, suggesting an intensified directing and liaison role for C.N.A. She stated that determining responsible self-direction required the commitment, courage and unity of nurses for success.

In addition to supporting standards and their implementation membership voted in favor of a number of resolutions concerning continuing education for nurses. Collective approval was given to:

- the cooperation between the MARN board of directors and the provincial health authorities and Manitoba Health Organizations to pursue avenues by which financial support for continuing education can be promoted in individual agencies
- approaching community colleges to develop courses for adult educators in the health field that can be conducted in various areas in the province
- requesting the Department of Continuing Education and Manpower to include health agency educators as well as individuals employed in the community college system
- requesting Manitoba Health Organizations Inc., to encourage its members to include provision in their agency budgets to allow staff members to attend relevant courses in adult education
- promoting the development of certificate courses and recommending that employment agencies provide financial recognition to nurses who have successfully completed approved courses
- investigating the feasibility of the continuance of a post-diploma certificate course in Community Health nursing to meet immediate and short term needs for nurses prepared to work in the community and exploring the establishment of a

Public Health Nursing Course to meet on-going needs for post-basic education

- promoting the development of a Baccalaureate Nursing program at Brandon University.

The Association's interest in continuing education was not limited to the local level. Encouraged by MARN's executive director, **Louise Tod,** and president **Marvelle McPherson,** MARN members participated in a project to raise money for the Canadian Nurses Foundation, a fund for the post-baccalaureate education of nurses throughout Canada. Members raised a total of $1,632 for C.N.F. and added a considerable number of new members to the Foundation. The money was raised by members who were sponsored by their colleagues for a ten-lap run around the University of Brandon track.

Other resolutions passed by delegates included:

- that the Board of Directors establish a means of formal recognition of specialized competencies of members
- recommending to all hospitals operating emergency departments inservice education on all aspects of the care of victims of sexual offences, calling on all hospitals to treat rape victims alike regardless of whether charges are to be laid, and recommending to all schools of nursing that curricula include all aspects of care of the rape victim
- urging the Minister of Health and Social Development to expand the province's Child Day Care Program and develop provincial licensing standards to child care facilities
- supporting research into identifying specific health needs of native peoples in Manitoba, supporting groups such as the Registered Nurses of Canadian Indian Ancestry ... and supporting groups within native communities who are interested in promoting health care
- continuing the Special Committee for the Position Paper on Occupational Health Nursing and delegating to them the responsibility of preparing a handbook on the "Role, Function, and Responsibilities of the Occupational Health Nurse."

Newly elected members to MARN's Board of Directors include: **Shirley Jo Paine** — second vice-president by acclamation; **Sister Bernita Ozubko —** member-at-large, Nursing Sisterhood, by acclamation; **Darlene Hamm,** inservice instructor at Portage District General Hospital — member-at-large; **Sue Hicks,** educational director, Brandon Mental Health Centre — member-at-large; and **Anne Friesan,** inservice coordinator, Bethesda Hospital, Steinbach, Manitoba — member-at-large. Two members were elected to MARN's Nominating Committee: **Jean Burrows,** instructor, Red River Community College, Winnipeg, and **Anne DeFehr,** V.O.N. and Home Care Coordinator, Winnipeg Municipal Hospital.

CNA Health Promotion Program: Phase Two

Thanks to a $23,124 contribution, recently granted by Recreation Canada, the Health Promotion Program of the Canadian Nurses Association will soon enter its second phase. These funds will be allocated to the first of three proposed workshops. These workshops will make up Phase Two of the Program.

The aim of the first workshop is to involve "nurse teachers" in the Program, to sensitize them to healthy life-styles and to increase their skills in multi-risk counselling.

Twenty-two nurse teachers chosen by CNA's member associations will be invited to the workshop. It is scheduled to be held September 6th to 11th at the YMCA Conference Centre, Geneva Park, near Orillia, Ontario. The five-day conference will feature formal and informal presentations as well as theoretical and practical sessions on life-style topics.

An important facet of the workshop will be the material sent to the participants for their pre-conference preparation. It will consist of background documentation, suggested readings and annotated bibliographies intended to set the stage for discussion on the relationship between health, fitness and life-style.

Criticisms and suggestions will be sought from participants through the use of open-ended questionnaires distributed at the time of the workshop and after six months have passed.

When the participants have returned to their own regions, it is anticipated they will act as role models in sensitizing other nurses and their clients to the concepts of health/fitness/life-style.

Funding for the second and third workshops will be requested by CNA at a later date. This first workshop will be produced with the assistance of the Fitness and Amateur Sport Branch, Health and Welfare, Canada.

Did you know ...

The Canadian Nurses Foundation is looking for a logo, an identifying design, and they're holding a contest to find it. They will pay $200 to the winner of their design competition and the contest is open to all interested persons.

To enter, submit your name, address and telephone number along with your logo design to: Canadian Nurses Foundation, 50 The Driveway, Ottawa, Canada, K2P IE3. The contest deadline is set for March 31, 1978 and the winner is to be announced in June of 1978. All entries become the property of the CNF and all decisions will be final.

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News

Performance expectations of new grads

The study **Performance Expectations of Diploma Nursing Graduates in Saskatchewan,** released by the Saskatchewan Registered Nurses Assocation in January of this year, has already had positive effects. At this year's May Annual Meeting in Regina, SRNA president **Sheila Belton** reported to membership that the Saskatchewan Hospital Services Plan would be providing funds this year for a one-month orientation program for all new graduates beginning work in hospitals of 50 beds or less. And this step is only the beginning.

The survey grew out of a resolution passed by SRNA membership at their 1975 Annual Meeting because nursing personnel in Saskatchewan hospitals and nursing homes had stated concerns about the nursing capabilities of beginning diploma grads, and because the new graduates themselves expressed concern about their ability to meet expectations of employers.

Performance expectations were defined by the Core Committee of SRNA's Committee on Registration and Admission to Membership as the attitudinal characteristics and nursing skills that the beginning diploma graduate is expected to demonstrate in the work situation. It was projected that survey results would benefit:

- funding agencies — for budgetary puposes
- employing agencies — for planning orientation and inservice programs
- nursing administrators — for staffing purposes
- educational institutions — for curriculum planning.

The survey involved the opinions of directors of nursing, directors of educational programs, and 1975 diploma graduates regarding the performance expectations of beginning graduates in their first employment experience in general hospitals or nursing homes. It dealt only with expectations on the first day of employment prior to an orientation period. The study did not concern itself with expectations for degree graduates or for those working in specialty care units.

The results of the survey indicated that:

- 1975 diploma graduates rate *observation and communication skills* higher as performance expectations than the other respondent groups.
- *personal care skills* were rated high as a performance expectation by all groups.
- *skills in assisting with nutrition and mobility* as well as *nursing techniques, diagnostic tests and preparation for treatment and patient teaching* were rated higher by educational programs than by the other respondent groups.
- *attitude and employment characteristics* were rated higher by directors of nursing in hospitals and nursing homes, and by 1975 diploma nursing graduates than they were rated by educational programs.

The question raised by higher scale ratings of performance expectations by beginning graduates compared to the rating of other groups was that: either the 1975 diploma graduates overrated performance expectations, or, directors of nursing in hospitals, nursing homes, and educational programs underrated them.

The survey results indicated the need to investigate the reasons for the differences in ratings by educational programs and by employing agencies. A need was also seen for identification of the *general performance expectations* which could best be acquired through the educational program and the *specific performance expectations* best acquired through orientation and on-the-job training.

The assignment of "charge nurse" responsibilities on evenings and nights within the first six weeks of employment by the majority of employing agencies raised questions regarding patient safety and reasonable employment practices. The survey results reflected a strong need for provision of an orientation program and opportunities for beginning graduates to work with experienced staff in order to develop confidence before assuming charge nurse responsibilities. A need was also seen for staff overlap during orientation periods.

The recommendations made by the report are all being followed up by SRNA through appropriate channels. The recommendations are as follows:

- The questionnaire utilized for this survey be further developed into a *Statement of Performance Expectations for Beginning Diploma Graduates in Saskatchewan.*
- Each employing agency state in writing its own performance expectations for beginning graduates on a progressive basis, as: end of first week, end of sixth week, of third month, of sixth month and of first year.
- In the interest of safe patient care:

1. Hospitals of 50 beds or less develop jointly an orientation program designed to their needs and utilize it consistently before requiring graduates to accept full responsibility on evening and night shifts.
2. Hospitals of 51 beds or more reassess their current orientation programs and nursing assignment practices and adapt them to better prepare beginning graduates to assume charge nurse responsibilities on the evening and night shifts.
3. The findings of the "Assessment of the Plains Health Centre Twelve-Week Orientation Program for Nurses in their Initial Employment Following Completion of a Basic Nursing Education Program," which indicate that with a planned and supervised orientation program, beginning diploma graduates are capable of meeting the defined agency expectations for clinical performance within the prescribed time period, be recognized as supportive evidence of the effects of an orientation program.

- The dangers inherent to patient safety when beginning graduates are required to assume responsibilities beyond their reasonable ability to cope (i.e. within 6 weeks or 12 weeks) be recognized by hospital trustees and administrators and appropriate steps be taken to prevent this occurrence.
- Funds necessary for the provision of adequate orientation programs in all hospitals including funds for the required instructional and relief staff be provided.
- In order to assist the beginning graduates in the transition from the student to the employee role, representatives of nursing meet regularly to reassess general and specific performance expectations and orientation requirements.
- That a follow-up survey be done by sending the questionnaire to 1975 diploma graduates upon completion of one year of work experience.

Core Committee members of SRNA's Committee on Registration and Admission to Membership involved in conducting the survey were: **Sister Bernadette Bezaire,** director of nursing at St. Paul's Hospital, Saskatoon — chairman; **Marion Jackson,** Saskatoon; **Patricia Kraus,** Wakaw; **Ina Watson,** Saskatoon; **Kitty O'Shaughnessy** Secretary, SRNA staff.

N.S. occupational health nurses hold seminar

"She is a member of a team. She is involving herself with the activities of the safety man, the industrial engineer, as well as with the physician. She has tremendous opportunities to improve health services to all in the world of work."

It is in this light that Frances Moss, executive secretary of the Registered Nurses Association of Nova Scotia sees the occupational health nurse.

Speaking at the Third Spring Seminar for Occupational Health Nurses, held in Halifax in May, Moss said she believes occupational health nurses are in a very strategic position right now, especially with the new emphasis on prevention (health) rather than cure.

"To some of us with an all-hospital background, you are indeed in an enviable position dealing as you do, basically, with healthy people."

Moss says occupational health nursing is a specialty. Practitioners of this specialty must apply professional nursing principles to developing and carrying out a nursing service that is tailored to the environment of the industry or facility as well as to the needs of the employees.

The two-day seminar focused on the functions and qualifications of occupational health nurses as well as progress made in the formation of a province-wide association of occupational health nurses.

Coordinator of the seminar was Margaret Grice who is president of the Halifax-Dartmouth Group.

Separate collective bargaining body for Alberta

Following an example set by eight other provinces, members of the Alberta Association of Registered Nurses are now considering a proposal which would serve to set apart as independent their collective bargaining body.

Since 1974 the AARN has been made up of two divisions:

- the Professional Development Division which is responsible for protection of the public by assuring that members maintain an acceptable standard of practice
- the Collective Bargaining Program which is responsible for development and negotiation of employee contracts.

Membership in the Professional Development Division of AARN numbers 12,000 registered nurses. Approximately 7,000 nurses participate in the Collective Bargaining Program.

There is apparent misunderstanding regarding the responsibilities of the Collective Bargaining Program as delegated by the Alberta Labour Act and those of the Professional Development arm as delegated by the Registered Nurses' Act. In order to clarify these roles, the Provincial Council of the Association has initiated action to provide for complete autonomy of the Collective Bargaining Program.

The proposal now before the membership would establish the Collective Bargaining Program as independent of AARN and would provide enough time for the orderly development of this completely autonomous body.

B.C. nurses join public employees

The Labour Relations Division of the Registered Nurses Association of British Columbia has voted to join that province's Public Sector Employee Coordinating Council (PSECC). The Council is an informal coalition of organizations representing public employees in British Columbia.

The Labour Relations Division is the collective bargaining arm of the RNABC, with collective agreements covering about two-thirds of the Association's 19,000 members.

The decision to join the Council was made by 168 voting delegates to the Division's annual convention. That convention was held on May 10, one day before the full association's three-day annual meeting. Both sessions were held at the University of British Columbia.

The Council's objectives are:

- to provide a united voice for members on matters of common concern to public employees in B.C.
- to coordinate efforts to promote the interests of public employees
- to educate the public in matters that will advance and protect the rights of public employees
- to share information dealing with matters of mutual concern.

Did you know?

Working under fluorescent lights is not good for you! Not only can the glare cause a general ill feeling, nausea, eyestrain and headaches, fluorescent lighting has been linked to bone disease and tooth decay in test animals, eye problems, certain learning difficulties and emotional depression. In 1967, Soviet researchers stated that people working under artificial lighting are susceptible to functional disorders of the nervous system and Vitamin D deficiency, weakening of the body's defences and aggravation of chronic diseases.

In Canada, no one has studied the effects of lighting on humans as yet. Maybe we should.

Health happenings in the news

Widespread interest in the **fiber content of the American diet** has resulted in a surge in consumption of bran cereals according to a report in the *Journal of School Health.* Total pound sales of ready-to-eat bran cereals have increased 20% during the last year in the U.S. (Data from A.C. Neilsen Company). "Consumers have reacted strongly to widely publicized medical studies reporting health benefits from diets in which the amount of fiber is greater than in most American diets," Dr. Robert B. Gravani, Ph.D., Science Director, Cereal Institute, Inc., stated.

Much of the current interest in fiber results from reports by Dr. D.P. Burkitt, a British surgeon, who observed that rural Africans whose diets are high in fiber-containing foods have a low incidence of several important diseases, including appendicitis, hemorrhoids, diverticular disease and cancer of the colon. Since these same diseases are much more prevalent in the United States and other countries where diets are low in fiber, researchers theorize that lack of fiber may play a role in the development of these diseases.

While many foods of plant origin contain fiber, the amount varies from one type of food to another. Some breakfast cereals are convenient sources of fiber. As an aid to consumers, the percentage of fiber in breakfast cereals containing significant amounts is increasingly being shown on packages.

The amount of crude fiber in the following foods is:

High bran content cereals 7.5%
40% bran cereals....3.5%
Raisin bran cereals....2.5%
Wheat germ 2.0%
Whole wheat cereals (shredded, flaked or formed)....1.8%
Hot whole wheat cereals 1.8%
Hot oat cereals....1.1%
Whole wheat bread....1.6%

Discovery that one strain of gonorrhea has recently acquired **total resistance to penicillin,** is a sign of things to come according to Dr. Alex Morrison head of the federal Health Protection Branch, Health and Welfare Canada.

Dr. Morrison predicts that "Scientists have begun the first lap of what may become a life and death race with bacteria, as more and more of the 'bugs' outwit antibiotic strains." He points out that, as bacteria acquire resistance to one antibiotic drug, scientists race to create another drug. He does not know if a time will come when researchers lose their perilous game of leap-frog.

"It is now ultimately a problem for the drug industry which must increase its efforts to synthesize new drugs," he says, noting that many of these newer, more exotic antibiotics have far more unwanted side effects than penicillin, which "is eminently safe for all but the few people who are allergic to it."

Antibiotic resistance will sharply drive up medical care costs, experts predict, because the new antibiotics are far more expensive than the old.

The Council on Drug Abuse has an action plan available which can help a community in **preventing drug abuse.** Free copies of the Community Conference Action Plan are available from: *Council on Drug Abuse, 56 Explanade St. East, Suite 303, Toronto, Ontario, M5E 1A7.*

Did you know ...

CNA Rules and Regulations have been revised to permit the submission in writing to the **resolutions committee** by any association member or ordinary member of a resolution signed by that member, throughout the year and up to the beginning of the 12th week preceding the annual meeting. The board of directors shall have the right, at any time up to the date of the annual meeting, to submit resolutions relating to the business of the board.

CONGENITAL DISLOCATED HIP

Celia Nichol



When parents are faced with the fact that their child has congenital dislocated hip, a potentially serious disability, their initial reaction is often one of alarm. They may grow more perturbed when they are confronted with the responsibility for the home care of their small infant, especially if the child now wears an unwieldy body cast or bulky abduction splint. Medical intervention constitutes an important part of the child's treatment. But the nursing care that the parents can give their child will depend to a large extent on how well the nurse is able to teach the parents. Effective teaching and support of the parents throughout the child's lengthy course of treatment depends on the nurse's understanding of the disability, her awareness of the infant's psychosocial needs, her rapport with the child's parents and practical know-how ...

Glossary

- **Abduction** — the lateral movement of the limbs away from the median plane of the body
- **Adduction**—the lateral movement of the limbs towards the median plane of the body
- **Anteversion** — tipping or bending forward
- **Avascular necrosis** — death of bone or tissue due to a poor blood supply
- **Congenital Dislocated Hip** — an anomaly in which the head of the femur lies outside the underdeveloped acetabulum or hip socket in a stretched elongated joint capsule.
- **'Dislocatable' Hips** — hips that are basically unstable; the femoral head may be passively dislocated from the acetabulum
- **Innominate Osteotomy** — the incision or transection of the innominate (hip) bone
- **Myotomy** — surgical division or dissection of a muscle
- **Reduction** — restoration to normal position
- **Subluxation of the Hip** — the lateral and upwards migration of the femoral head from its normal position. Unlike dislocation, in subluxation the femoral head is still in the acetabulum.
- **Tenotomy** — surgical transection of a tendon

Congenital Dislocated Hip has all the potential of a serious and crippling anomaly. Early discovery of the problem can usually mean complete correction through medical, surgical and nursing management, but the chance of successful treatment declines remarkably as the infant grows older. Understanding the disability and its treatment is one important consideration in providing thorough nursing care.

Congenital dislocated hip is a condition that affects between 1.5 to 1.7 infants in every 1,000 births. [1] In more than half these cases, the condition is bilateral. [2] It is estimated that one in 60 to 80 infants are born with unstable or dislocatable hips, but that only 12% of these babies will progress to the point of actual dislocation. [3] CDH appears eight times more frequently in girls than in boys [4] and shows a familial tendency in 20 to 30% of recorded cases. [5] Specific child care practices increase the incidence of the anomaly in some countries.

There are a number of theories regarding the hereditary and environmental factors contributing to CDH. In utero, the hip joint of the fetus develops by being held in a position of acute flexion. A baby born with dislocatable hips exhibits an unusual degree of hip joint laxity (possibly due to genetic factors or the mother's hormones during pregnancy). If, in the first few weeks of life, this baby's hips are passively extended from the uterine position of flexion, the hips may dislocate or sublux. Passive extension of an infant's hips may occur during a breech delivery, where the incidence of CDH is 30%,[6] or because of child care practices that adduct the infant's hips with tight blankets or cradle boards, as seen in Germany, Northern Italy, or according to the custom of some North American Indians.

Persistent dislocation or subluxation of the femoral head from its normal position in the acetabulum leads to secondary changes in the hip joint, changes that prove more severe and less reversible with the increasing age of the child. These changes include:

- acetabular dysplasia, resulting in a shallow, maldirected acetabulum
- an increase in the normal femoral neck anteversion
- hypertrophy of the stretched elongated capsule
- contracture and shortening of the muscles crossing the hip joint, the iliopsoas and adductors
- delay in ossification of the femoral head
- development of a secondary false acetabulum in the ilium, if dislocation continues.

Diagnosis and Treatment

Diagnostic signs of CDH vary according to the age of the child, and treatment of the anomaly depends upon the age of the child at diagnosis. The following is a summary of diagnostic signs and treatment according to the child's age:

Birth to three months

Instability of the child's hip joint can be felt and sometimes heard through the Ortolani test. In this test, the infant's flexed hips are abducted to produce the "click" of reduction, a sign usually present only in the neonate. As the baby's hip gradually tightens in the dislocated or subluxed position, limited abduction becomes the more important diagnostic sign. Asymmetry of the child's gluteal skin folds are also an important indicator of CDH at this age.

Treatment for early diagnosed CDH consists of gentle reduction of the dislocation and maintenance of the hips in the stable flexed abducted position. This may perhaps be done initially with plaster and/or a splinting device such as the Frejka Pillow, Pavlic Harness, or other abduction splint. In the very young infant whose hips are not too unstable, bulky diapering with several diapers or towels may be used to keep the child's hips in a stable position. This course of treatment is followed for two to four months until the joint capsule is

tighter and the femoral head has stimulated the development of the acetabulum. A child treated at this age can be expected to develop a normal hip.

Three to 18 months

In an older child, the adduction contracture of the hips is more pronounced. There may be an apparent shortening of the involved leg, and the perineal area may be wider than normal, particularly in the child with bilateral CDH. "Telescoping" can be felt as the child's femur moves within the thigh. As she begins to walk, the child will have a Trendelenberg gait, in which she shifts her body weight to the affected side. If she has bilateral CDH, the child will have a waddling gait. X-rays will reveal acetabular dysplasia and delay in ossification of the femoral head, which is displaced upwards and laterally in varying degrees from its normal position.

Initial treatment at this age involves the use of Split Russell or Bryant's traction to pull the femoral head to a position opposite the acetabulum and to loosen the tight adductor muscles. This is followed by percutaneous adductor tenotomy, closed or if necessary open reduction and the application of a hip spica cast. The cast maintains the child's hip in the position of greatest stability, usually 90° to 110° flexion and 50° to 60° abduction.

The child's hip will be immobilized in this way for three to 18 months depending on radiographic evidence of progress and the doctor's preferred mode of treatment. The cast is usually changed several times during this period. Following cast removal, the child may be maintained in an abduction splint for a variable length of time, during which her normal activities are gradually resumed. The prognosis for normal hip development is good for 80% of the children treated at this stage, the better prognosis for younger babies.[7]

18 months to five years

In the older child, the secondary changes induced by CDH are much more severe and usually a longer period of traction is required for treatment. Skeletal traction is occasionally used. Subcutaneous adductor tenotomy or open adductor myotomy may be followed by an attempted closed reduction. Because there is only a 30% success rate for this procedure at this age,[8] open reduction may be combined with reconstructive surgery. Innominate osteotomy, a procedure aimed at redirecting the acetabulum to obtain a better hip joint, may be necessary. Even with this approach, results of treatment are not as successful as those obtained by treatment in the first three months of the child's life.

Five years and older

Fortunately very few children with CDH reach the age of five without diagnosis. The severity of secondary changes at this stage usually prohibits success even with extensive bony surgery. In adult life, only palliative procedures may be done to alleviate the pain of severe arthritic changes.

Certain complications accompany the treatment of CDH, among them:

- redislocation and avascular necrosis of the femoral head
- fracture of the femoral neck or subtrochanteric region due to prolonged immobilization
- nerve paralysis.

Nursing Care

Treatment of the child with congenital dislocated hip involves the cooperative effort of a variety of medical and paramedical workers. Nurses working in many areas, whether in the newborn nursery, public health, pediatric, clinic and office settings, have an opportunity to detect CDH in a child. Their careful observations, or the concern expressed by parents should alert them to signs of possible problems. If nurses have any suspicions about the possibility of CDH they should encourage parents to seek medical attention for the child immediately.

Parent teaching is perhaps the most important aspect of nursing the child with CDH. After all, it is the parents who will be providing most of the direct care to the child while she is in an awkward cast and/or brace. The nurse needs a thorough understanding of the condition, its treatment, and normal child growth and development in order to teach and support the parents adequately in their care. An awareness that the treatment of CDH deprives the infant of the normal opportunity to carry on certain developmental tasks is required to ensure that special provisions are made by the parents to meet the child's needs.

When an infant with CDH is admitted to the hospital for traction, her parents are usually very anxious, in need of reassurance and emotional support. Often they have just received the news of a potentially severe congenital problem. Initially, they may be horrified at the traction apparatus applied to their baby, but after they are helped to deal with these initial reactions, they are ready for explanations and ready to begin to participate in their child's care.

Nursing the infant in traction involves the use of general principles of traction care, including observation of the neurovascular status of the limb(s) in traction and the condition of the traction apparatus. Psychological considerations of the baby's care need not be neglected. Some doctors allow the infant to be taken out of traction for feeding, so that for this period of time, the child can be cuddled. Surrounding the baby with brightly colored bumper pads, possibly brought from home, may give the child a greater feeling of security. If it is feasible with the home situation and in accordance with hospital policy, the mother may be encouraged to take part in her baby's hospital care. Diversion through the use of mobiles, toys and frequent staff visits also help the child to be more comfortable.

Care of the child in a hip spica

After adductor tenotomy and closed reduction, the child is placed in a long or short leg hip spica cast. At first many parents are overwhelmed by the size of the cast and the prospect of caring for the baby in this cast at home. While the child is in the hospital and her cast is drying, the nurse can gently reassure the family and tell them what they need to know in order to care for the baby at home. Her instructions and demonstrations can be supplemented by a written information sheet that the parents can refer to when they take their baby home.

Skin care

Good skin care is a very important aspect of nursing the baby in a spica and it is necessary to promote healthy skin and to prevent cast sores. Each day, the baby should be washed and dried on all exposed areas of her body and as far under the cast as her mother's fingers can reach. Several times daily, alcohol should be rubbed on the baby's back, on bony prominences and along cast edges. This helps to refresh and toughen the baby's skin. Parents should be told to avoid the use of powders and lotions. They should also be cautioned against tucking extra padding along cast edges in an attempt to protect the child's skin — this only creates pressure points and predisposes to skin breakdown.

Care of the cast

Keeping the cast dry and clean is one of the most challenging aspects of the child's physical care. Most hospitals initially set the child on a Bradford Frame with a urinary drainage system to ensure thorough drying of the plaster without soilage with urine and stool. The child may or may not be sent home with this setup, depending upon hospital policy. Parents are often quite perturbed by the appearance of the frame and its use ought to be explained. Whether or not the child is to be nursed at home on a Bradford Frame, her head should be elevated to promote downhill drainage of urine. This may be accomplished by placing blocks under the frame at the baby's shoulders, or by raising the head of the mattress. The mattress should have a waterproof cover.

Careful diapering is important for protection of the cast, and the baby's skin. The mother should be shown how to diaper her

baby while the child is in the spica. First, the diaper is folded so that it is slightly larger than the opening in the cast that it is to fill. Then, a piece of plastic food wrap is cut, slightly larger than the folded diaper. The diaper is then placed on top of the food wrap. The mother should be shown how to tuck both diaper and plastic well under the cast edges, so that the wrap is on the outside and extends beyond the diaper to prevent it from touching the cast. Disposable diapers may be cut to size and inserted in a similar manner, with the plastic backing against the cast surface.

Diapers should be changed frequently. If the cast does become soiled it may be wiped clean with a damp cloth and a cleansing agent without bleach, such as Bon Ami.* A wet cast can be dried with a hair drier turned to the cool setting.

"Petalling" the cast

Finishing the cast edges with waterproof adhesive tape will assist in keeping the inside and outside of the cast dry and in smoothing the rough edges that could abrade the infant's skin. "Petalling" is usually done by the nursing staff two days after the application of the cast, when the plaster is completely dry. If the baby goes home before her cast is dry, the mother should be carefully instructed in the application of tape petals. If necessary, provision can be made for the community nurse to assist the mother with this procedure in the home.

Before petalling the cast, the nurse should make sure that the cast is properly trimmed to allow adequate breathing and eating room at the abdomen and space for diapering in the perineal area. On short leg spicas, the nurse can check to see that the cast is properly trimmed — a poorly trimmed cast can create dangerous pressure in the popliteal fossa.

Signs to watch for:

Parents who care for their child while she is in a cast need to be told about certain signs that should be brought to the attention of their doctor without hesitation. Such signs include:

- swelling of the baby's extremities
- discoloration or coldness of the baby's toes
- an unusual odor or elevated temperature without apparent cause
- unusual irritability of the child
- softening or breaking of the cast. If the cast softens or breaks, it may no longer maintain the child's hips in the correct position.
- signs that the baby appears to be outgrowing the cast.

Psychosocial needs of the baby

In her contact with the parents, the nurse is given the opportunity to assess their ability to meet the child's psychosocial needs, and to provide them with the necessary guidance. Most infants, although initially frustrated by their immobility, adjust to it very well. Older children who are used to walking prior to treatment, may find adjustment more difficult, and therefore need appropriate support.

The infant in the hip spica should not be left to lie in her crib all day. She needs stimulation and body contact in order to develop well. Her mother can be encouraged to vary the child's position. The child can be propped up in a stroller or chair with pillows, allowed to crawl on the floor, and be cuddled in her mother's lap. Some imaginative parents have constructed special chairs for their children, chairs that they can continue to use when the cast is removed and an abduction splint is being used.

The baby needs diversionary toys and mobiles. Parents should be cautioned against giving her small toys that might be slipped inside a cast. They should be taught to check the cast from time to time for the presence of small toys or bits of food that could cause skin breakdown.

Caring for the Child in a Splint

Care of the child in an abduction splint is generally the same regardless of the child's age. To the parents of the neonate, the brace is tangible evidence that their baby is not normal, and they may need help in accepting the problem. Parents of the older baby who is graduating from the cast to the splint will probably welcome the splint as a sign of progress, although they invariably feel discouraged at the length of time that treatment requires.

The doctor orders the amount of time that the child is to spend in the splint, and the parents should be told to follow this schedule carefully. Initially, the baby usually spends 23 hours a day in the brace; the brace is removed only for baths and diaper changes. As the child's acetabulum develops, the time she spends in the brace is usually decreased.

Good diapering is just as essential for the child in the splint as it is for the child in a cast. For the child in an abduction device like the Frejka pillow or bulky diapering, the heavy covering of the baby's perineum may predispose her to diaper rash, particularly in hot weather. Frequent changes aid in keeping the splint clean and the skin healthy.

Parents may be advised to place young infants on their abdomens for sleeping, as this position further helps to keep the child's hips in the corrective position, as does carrying the baby in a straddling position on her mother's hip.

Parents of older children need to be cautioned against using Jolly Jumpers** for their children. The use of walkers should also be discouraged. The child should not be encouraged to stand, cruise or walk in her braces. The nurse needs to understand how difficult and frustrating it is for parents to have to discourage their child's mobility. Older children often begin to walk in their splints, despite all opposition — sometimes the use of a sitdown toy car will discourage this tendency. Persistent ambulation in the brace should be reported to the doctor as many feel that this may contribute to unwanted forces on the hip.

Public Health Involvement

The public health nurse has an important role to play in aiding the family of the child with CDH. If she has not been involved with the detection of the problem, her first contact will generally follow a referral from the hospital where the baby is being treated. She can help the family learn to care for their child when she first comes home, and reinforce the teaching done at the hospital before the baby's discharge. In addition to teaching, she can provide ongoing support and reassurance to the parents as they begin to adjust to their baby's disability. To provide realistic teaching and support, it is important that she maintain a close contact with the child's doctor and with the clinic or hospital where the baby is being treated.

** Bon Ami is a registered trademark of Standard Household Products Corp.*

*** Jolly Jumper is a registered trade mark of International Pediatric Products Limited.*



Lisa, in a long leg hip spica cast, sitting propped up on a chair with a pillow. Note the tape "petals" around the perineal, ankle and (not seen) abdominal areas.

Photos courtesy of Children's Hospital of Eastern Ontano

LISA

When Lisa was only three months old, her mother noticed that the child's right hip had limited movement, and began to find it increasingly difficult to clean the crease in the child's right groin. A month later, Lisa's pediatrician referred her to an orthopedic surgeon who confirmed through examination and X-rays that Lisa's right hip was dislocated. It was the doctor's opinion that at birth, Lisa's hip had a predisposition to subluxation, but that without treatment, it had progressed to dislocation a month before diagnosis. (Lisa's six-week examination had revealed no abnormal findings.) At four and a half months old, Lisa was admitted to hospital for treatment.

A week before her surgery, Lisa was placed in Bryant's traction. This marked the beginning of her family's adjustment to the long period of her treatment. Her mother had to face the immediate problem of how to breast-feed Lisa and the family and staff aimed at keeping her happily entertained while she was in traction. But these details of care were only part of the larger problem of learning to accept that Lisa, who seemed so 'normal', had a serious defect, one with the potential of long-lasting effects.

On Lisa's admission to hospital, the nurses spent a good deal of time with her mother, encouraging her to verbalize her feelings, answering her questions, and trying to prepare her for Lisa's further care in a hip spica cast.

A week after admission, Lisa was taken to the operating room where a percutaneous adductor tenotomy, closed reduction and application of a hip spica cast were performed under general anesthesia.

Initially, Mrs. M. was overwhelmed by the size of her daughter's cast. However, she became more comfortable with it in the two days before Lisa's discharge, and gradually, with the help and encouragement of the nurses, she began caring for Lisa herself. The appearance of the Bradford Frame bothered her at first, and she was reassured to learn that she wouldn't have to use it at home. On Lisa's discharge day, a nurse "petalled" her cast with waterproof tape and final arrangements were made for a public health nurse to visit Lisa and her family at home.

Mrs. M. managed well at home — much better than she had imagined. Lisa's sisters and brothers were delighted to have their baby sister back at home, and kept her happy by playing with her. To her mother's amazement Lisa adjusted quite happily to her cast and seemed quite comfortable in it. Mrs. M's main problem lay in keeping the cast clean and dry, but following the guidelines given to her at the hospital, she grew confident and successful in this aspect of her daughter's care.

After five weeks at home, Lisa was readmitted to the hospital for a one-day stay and her hip spica was changed under general anesthesia. Examination proved that both hips were stable, and X-rays showed the right hip to be in good position.

Mrs. M. was a little anxious taking Lisa home that day as her daughter's cast was still wet, but the nurses in the day care unit offered advice to her on how to dry the cast. Two days later, the public health nurse, already familiar to Lisa's family, came to assist Mrs. M. in applying tape petals to the cast.

Mrs. M. was much more comfortable caring for Lisa in her second cast, and wasn't perturbed



X-ray showing Congenital Dislocated Hip in a twenty-month-old child. Note the upward and lateral displacement and delayed ossification of the right femoral head as well as the oblique, dysplastic acetabulum.

even when the cast broke at Lisa's right thigh. She just took her daughter to the hospital plaster room where the damage was quickly repaired.

Two and a half months after the initiation of treatment, Lisa's hip spica was removed for good; her X-rays showed centering of the femoral head and good development of the acetabulum. Mrs. M. was thrilled to have Lisa's cast removed, although she was somewhat worried about injuring Lisa now that her hip was protected only by a plastic abduction splint. It was a day of celebration in the M. household.

From then on, Lisa made regular visits to her doctor for examination and X-rays that indicated continued improvement in her hip. Initially Mrs. M. was disappointed that Lisa's progress in the brace seemed so slow; she had hoped that the brace would only be necessary for a few weeks. Gradually, with help from an understanding doctor and nurse, she accepted Lisa's slow but steady progress and found encouragement in her small steps towards improvement.

Three and a half months after the cast was removed, Lisa was allowed out of her brace for four hours each day. Two months later, she reached the stage where the brace was only necessary during the night . By this time she had developed her own way of crawling in the brace — she sat on her bottom and pushed herself backwards much to her family's amusement.

At 13 1/2 months old, nine months after the initiation of treatment, Lisa stood for the first time. By this time, her brace had proclaimed old age. Mrs. M. had been told not to replace the brace after it had worn out. A month later, Lisa was cruising, and at 16 months of age, to the joy of her family, she began to walk independently.

Lisa will continue to visit her doctor, increasing the intervals between visits so that the doctor can check her hips and record her development. Her prognosis to live a healthy, active and normal life is excellent, thanks to early and comprehensive treatment.

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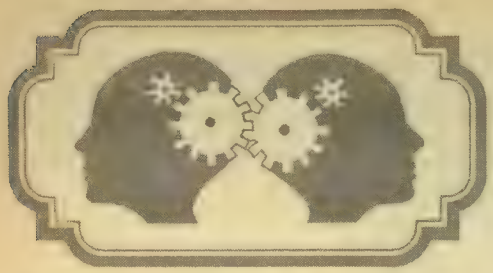
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connection

A Gift of Tomorrow

Five years ago, Patricia was an active young person who loved to dance, to skate, to bowl and to travel. She was learning to swim and had plans to take up skiing the following winter. The events of a few moments changed all of that. Now, as she says, she lives in a chair. This is her story of what it's like to become a paraplegic.

Patricia Harcourt French

As a paraplegic, mine is a silent cry of desperation — "I want to live." I want to live — but not as I do now in a tiny 16"x16" world. I want to live as I did before, doing all the things I used to do — knowing the fascination of things left undone because of the certainty that there will be a tomorrow. My tomorrow died the day of my accident.

Each of us knows that death will come eventually, that it is the completion of the life cycle. But we are not aware of it daily; it is a date with the future and so we do not think of it. We are too taken up with the challenge of living. As a paraplegic my emotions are mixed: there is fear of living and fear of death and the unknown.

The past five years have passed so quickly that it surprises even me. It has been a period of heartbreak, pain, both physical and mental, hopelessness, and loneliness. For me, that is surprising — I, who never knew the meaning of the word, and yet it is not loneliness in the true sense of the word. It is the fact that I cannot get up and go, do all the things I loved to do. And, of course, there have been many, many tears — enough to fill an ocean.

As a child I can recall how I hated to see anything caged, never thinking that one day I would be trapped in a prison such as this. Perhaps time will teach me the true meaning of 'mind over matter' and this chair will cease to be a prison! Have I thought too much of bodily freedom? Someone who is free might think so. But is that not the goal of each of us — to keep ourselves — mind and body — free? It seems to be a vicious circle. Why are we not taught as children that freedom of the mind is far more important than physical freedom so that when it is taken away we are more able to cope with its loss? A foolish thought — it takes time, patience and effort to learn the true meaning of mental freedom.

It never entered my mind, as I suppose it never enters the mind of most of us, that I would become a paraplegic. These things only happen to someone else! And then one day I was faced with the fact that I was paralyzed and I had to learn all that goes with the helplessness of a useless body. Oh, you learn to live or at least exist. You are taught the necessary transfers, the routine of daily living and, of course you improvise as you go along, meeting every situation with an attempt to overcome it, or a 'would you please do this or that for me.' You are even taught to get in and out of your chair but often when the need arises your teaching goes by the board and then you know the humiliation of dragging ycurself to a telephone and asking for help. It is like watching proud animals in a circus being put through their paces. It brings no pleasure to watch the dignity of these once proud beasts destroyed.

Why is it when we are brought in all battered and bruised and probably near death, and doctors know that we will be confined to wheelchairs for the rest of our life, that we are not left to die with some dignity? Surely that is our right. You will say the doctors are doing what they must — abiding by their oath. But I wonder whether anyone has ever stood outside himself and watched this procedure — each person doing his share to complete the 'finished' product on an ' assembly-line.' Do these people ever think of our physical and mental anguish during our progress down this assembly-line? No, that is not part of their job. And so,eventually,you leave the hospital to embark on another phase of your new life.

Rehabilitation

At the rehab center, you go through days, weeks, months even years of fighting for a new way of life. It is here that you slowly come to realize what it is to be confined to a wheelchair. Each little hurdle you come up against and eventually surmount brings its own share of heartache, mainly because it is something you had no knowledge of before and so do not know how to contend with. Some of the incidents I could never put down on paper. I can only compare this learning process to tha of a baby who has the mind of an adult.

The months stretch ahead. You learn again to do all the simple things that you learned as a child. The time this takes differs from person to person. You fight for days just to lift a leg onto a bed for a transfer; you learn to use your arms in place of your legs and to strengthen them with various exercises so that eventually they compensate, in the activity of daily living, for the loss of your legs. But, *make no mistake, nothing can ever compensate for the loss of one's legs.*

When you enter this new world there are so many things to contend with all at once. At the same time you must surrender your privacy. And so you fight all the harder to cling to your last shreds of identity because this is all that separates you from the crowd. This is your pride, your heritage, your individuality. And so the fight continues from day-to-day, minute-to-minute. You overcome one obstacle only to be deflated by another!

A disabled person learns very early to take just one step at a time. As Dr. Schweitzer said, it is better to light a small candle than to remain in darkness. I sometimes think that before my accident I was a great big chandelier. When it shattered into a million pieces, all that was left was a tiny candle. Now I often stumble and fall because the glow from that candle encircles a very small area, but recently I have been surprised to find that others have seen and followed that little light as well—like moths gathering around a flame.

A wise man once said: "You only have this moment, tomorrow is a gift from God." How very true for a paraplegic or quadriplegic. Do we not live on borrowed time?

Patricia Harcourt French, *author of "A Gift of Tomorrow," has learned to cope with her disadvantages and now holds a responsible position as medical secretary to a neurosurgeon in a Toronto hospital. Her interests include meeting new people, gourmet food, sketching, reading, crewelling and taking care of plants. When she wrote "A Gift of Tomorrow" three years ago, she says it was not intended for publication but simply a way of expressing her thoughts and feelings.*

The Canadian Institute of Child Health: A Personal Responsibility

On July 1st, 1977, the Canadian Institute of Child Health began operation in Ottawa. The purpose of the Institute is to act as an advocate on behalf of children regarding their health needs. What relevance will the Institute have for us as nurses involved directly in the care of children? How can we actively participate in its aim to improve the health of our children?

Shirley Post, a nurse involved with the development of the Institute since its beginning says nurses are in a key position to help ...



Sharon Andrews

Shirley Post's involvement with the Institute of Child Health really began a full two years ago. The Hospital for Sick Children Foundation in Toronto commissioned her to examine the need for an Institute of Child Health in June of 1975. For six months Shirley travelled across Canada talking to people and organizations concerned with child health. After compiling her data she submitted her report to the Foundation in April of 1976. Shirley's research and study led her to endorse the concept of an Institute. Now the Hospital for Sick Children Foundation and the Canadian Council on Children and Youth have agreed to co-found the Institute of Child Health.

I talked to Shirley about her involvement; past, present and future.

Q. A considerable amount of time passed, Shirley, from when you finished your study to this announcement of the formation of the Institute. Were you beginning to doubt it would ever be formed?
Shirley: Oh no, by the time I finished the report I was really convinced that we needed some sort of an organization in Canada that really spoke out as far as child health was concerned. I guess I had talked to enough people and identified enough issues that I really felt it was time someone started to take action in some of these areas. You know, there were times when I told myself this was an important enough thing that if The Hospital for Sick Children Foundation didn't act on it I'd do it myself, even if initially it was just trying to get groups of mothers together.

Q. Why do you believe it is so important? Why does Canada need an Institute of Child Health?
Shirley: Well, what has tended to happen in Canada, and what I feel is one of our biggest problems, is that children have become lost in the overall picture. That, because there hasn't been anyone there to ask, "Hey, what about the kids?" or "How is this policy or that legislation going to effect the children?" quite bluntly, children have, very often, been overlooked. Did you know there are eight million children in Canada right now?

Q. Quoting the Institute's press release you define health as "complete physical, mental and social well-being and the mission of the Institute is to be an effective and useful force to improve the health and, therefore, the quality of life for Canadian children". Considering this involves some eight million people that's almost awe-inspiring.
Shirley: I think it's important to remember that we're not calling for a revolution. I mean there are some very worthwhile child health programs in the country but the problem is, they're spotty both regionally and economically.

What we have to do in Canada is change some of our priorities. We have to work together to put these programs into a more integrated network of services for the child.

Q. The Institute is to take a *"multidisciplinary"* approach to child health. What is it you mean by this?
Shirley: You see, we feel a lot of the problems in child health today are not strictly medical. A lot of them are classified by some people as "new morbidity" problems. These are things such as learning disabilities and all of our teenage problems like suicide, venereal disease and unwed mothers. The doctor alone won't be able to solve all these problems. It's really going to take the cooperative efforts of all of our professional people — our doctors, nurses, psychologists and teachers. We really have to work together towards a common goal.

Q. In your report to the Foundation you point out that during the course of your travels across Canada you talked to 200-300 people about child health. Who was it you talked to?
Shirley: I talked to doctors, nurses and other people in the health care profession. I talked to university professors. But, more importantly, I talked to a lot of parents and consumers and really anyone who would listen to me. In some areas I was on television and open-line radio shows telling people that I was there and talking to them about the study I was doing. As a result of those appearances I got a number of letters and phone calls from people who wanted to talk about issues they thought were particular problems.

Q. What did the people you talked to have to say? What were some of their worries?
Shirley: There were different things. For instance, I remember school teachers talked to me about what they thought was the poor state of health of the children in their classrooms. They were worried because their students weren't getting proper nutrition, their immunizations weren't up-to-date. The children were coming to school, a lot of them, neglected — dirty — and the teachers were concerned about the general state of health of these children. They would point out to me they couldn't teach a child if he hadn't had a good breakfast or a good dinner or if he hadn't been put to bed so he'd have a good night's sleep. If a child sleeps in the classroom he's not going to be able to learn anything.

Q. What about the organizations you spoke with? What were their reactions to your study?
Shirley: If I can use an example, the Canadian Pediatric Society has been very interested in the Institute. We talked to them about it and they were very supportive. They had a conference in Montebello a number of years ago, I guess it was about five years ago, called *Unmet Needs in Child Health*. The point I'm



trying to make is I didn't discover the wheel myself, we know we've had these problems for a long time. But I guess the thing is, even although the Pediatric Society had the Conference and talked about a lot of these "unmet needs," nothing had happened since the conference. Nothing had been done. This is where we hope the Institute is going to be different. We're going to be action oriented and we're going to take some of the reports and recommendations on child health and see if we can't get something done.

Q. How? I mean I'm sure every organization begins very idealistically only to find themselves immobilized by red tape and administration a few years later. How will the Institute avoid this and be action oriented?

Shirley: How? Well, you don't do it overnight and I think you have to have your long range objectives in the back of your mind all the time. We'll need some sort of comprehensive, integrated plan for child health. Then we'll have to ask ourselves just what that means and what kind of guidelines we'll have to set up to follow our plan. We'll have to decide just what the elements in this grand plan are to be. Then, and only then, will we be able to start picking up these pieces, or elements, one at a time. We'll try, I think, to get other organizations and people right across the country interested in them.

I'll give you an example. Let's take chronic care children with long-term problems. We've got a lot of these kids around right now. We could get people to take a look in their community, or region, at what kinds of services are available for those kids. We should get people to look at those services, not just in terms of acute hospital care, but in terms of primary care and of follow-up care. What's the role of the Crippled Children's Society in their area? What's the role of the school, the Department of Education? What kind of recreational facilities are available for handicapped children in their area? Is there an emergency or a crisis center? If parents need to get away for a weekend or for a holiday, what happens to these children?

I think what the Institute can do is provide the questions. We'll have to get community groups, medical groups and nursing groups looking at these questions, asking themselves, "Have we got this in our community, is it possible to have this in our community? And how can we put the pieces together to get an integrated, comprehensive system of health care for this particular child?"

Q. Do you then see the Institute as a coordinator, so that you provide the impetus for this kind of discussion and/or action?

Shirley: Yes, that's right, impetus is the right word. I see the Institute as being the impetus or the catalyst for getting some of these things before the public or before national organizations. Our function will be to say, "Let's stop a minute and take a look at that kind of thing. Can we do that better, or should we have a provincial, or even a national, policy on that?"

I think it's important to mention that there are a lot of good health care programs in various areas around the country. I think, if we could, the Institute would serve an important role even if we put people who don't have a particular kind of program in one area of the country in touch with people from another area who have.

Q. How do you propose to do this? How would the Institute act as a catalyst?

Shirley: I think there are many ways to start. I've mentioned the Canadian Pediatric Society. I'm also very interested in getting the Canadian Nurses Association involved. At their annual meeting in Halifax last year the CNA passed a resolution in which they supported the idea that they should get more involved with child care and child health.

One of the things I think the CNA might do, that would be most useful, would be to take a look at what nurses are doing in nursing curriculums right across the country to see if it is appropriate to the promotion of child health — checking to see if people are really teaching growth and development as well as teaching some of the social problems concerning children.

At a national level I think we could take a look at the graduate education programs for pediatric nurses; trying to find out just what a pediatric nurse is and how a nurse should/could go about getting extra training in pediatric nursing. What kind of programs do we have in Canada where the nurse can get this kind of graduate education? One of the complaints I hear from a lot of directors of nursing, not just at Children's Hospitals, but also directors of nursing who have Pediatric Units in their General Hospitals is it is very hard to find pediatric nurses who have had experience or who have had extra pediatric training.

Nursing and nurses are just beginning to get interested in research and I think this whole area of child care and pediatric child care is one area where nurses could make valuable contributions by getting some studies started.



Q. In many ways the Institute sounds very much like it will serve as an educator.
Shirley: Education will be a big component of our program. For example, we've got to educate the professionals as far as children are concerned insofar as they must learn to play a broader role or be more aware of the broader aspects involved in child care. I think it's important that we stress growth and development with our nurses, our medical students and our social workers. It's important for us to make them aware it's not just the sick child in the hospital they should learn about or understand but also the role of the child in the community. What's going to happen to that child in the community when he goes home because so often now just a few weeks later he's back with the same old problem? In that regard I think hospitals, in addition to their education, service and research components are going to have to add another component which is really social responsibility.

Q. What about research in general? Will the Institute sponsor studies themselves or will they encourage others to get it done?
Shirley: Yes, well certainly we're going to be doing some research but I guess the way I see us doing it is by encouraging other people. We'd encourage those people who wanted to do projects in certain areas or wanted to take on certain research or a certain study. We would support and help them rather than doing a lot of the research ourselves. But in the same vein we do intend to set up task forces to look at particular problems in certain areas. When you go to look at a problem you're certainly going to have to do research in terms of looking at what has already been done, collecting up the studies and the data and making some recommendations about what you can do.

Q. Perhaps we can talk about some specifics right now. What are some of the problems in child health you found through your study that you think the Institute might look into?
Shirley: Of course the Institute's Board of Directors will be responsible for deciding just what things the Institute will do first. Right now, we've not set any priorities but we have received a number of suggestions. As far as specific problems go there are several groups of children we could talk about. There's the preschooler and the infant. Many people say we should start there. In this area we would worry about immunization, proper nutrition, genetic counseling and early screening for things like hearing and vision disabilities. The argument here is the fact that if you catch things early it's going to be less costly and cause less emotional trauma. So there is a possibility the preschooler and infant will be an area we will concentrate on.

The other area that a number of people are saying we should put most of our efforts towards, or do something about, is the adolescent. These people point out there really isn't any one group interested in, or working with, the adolescent problem. We know from statistics that adolescent suicides are on the increase. We know that despite contraceptive measures and sex education there's been an increase in the number of adolescent unwed mothers.

Q. How could the Institute help adolescents?
Shirley: We'd have to go to the teenagers. That is, we'd have to go back to the school system. We'd take a look at what's going on in the high schools in terms of physical education, counseling and sex education.

I think the question we have to ask ourselves is how are we going to reach these young people at this stage in their life? Some people say we're not even trying right now, that things like physical fitness in our high schools are no longer compulsory, that health education or sex education is poorly taught and often not taught by nurses or doctors or appropriate people. I think in this case we'll have to go back and work within the school system.

Q. How can we as health care workers reach the preschool child? School is the great organizer where we can contact the children en masse, but how do we reach those who are not yet at school?
Shirley: There are some good pilot projects around the country in that area. They have an excellent one in Yarmouth, Nova Scotia and it



was funded by a special grant. They had a small group of professionals there (a psychologist, a person to test vision and hearing, etc.) and their goal was to bring these children in, all the children in the county, at three years of age. The parents were sent a little notice that this service was free and available and, you know what, the people came! They brought their children in from all over the county. A lot of things were picked up early with these children and very often time is our most serious problem. We say that a child has a learning problem but we don't find out until he's in Grade One or has failed that he really can't see straight or he can't hear what is being said.

It is important to realize that there are people doing this kind of thing right now. It's just a matter of getting it organized throughout the country and getting our priorities straight.

Speaking more generally about the kinds of problems we'll have to look into at the Institute and as health care workers, I can mention the unique problems of native children, the disparities of wealth and nutrition in Canada as well as the problems created in a single parent family.

Q. Shirley, what is it that not the Canadian Nurses Association, but the Canadian nurse can do for child health? I'm referring here to both the working and the non-working nurse.

Shirley: That's a good point because in the long run if we're going to change things, we have to take child health on as a kind of personal responsibility. I think nurses are in a great position to take a look at where they sit as individuals versus the child. Nurses are in the community, in the neighborhoods and they should ask themselves what they can do right there to improve the quality of life and the health of the children in their own area. What is really going on?

For example, I think there's lots of things nurses working in children's units in our general hospitals can do. For twenty-five years now we've been saying parents should have more liberal visiting hours, that children need not only physical care but emotional care and support, that means play programs. Nurses should ask themselves what kind of liaison they have with the school system, are the children in their units able to carry on their studies? You know, I really don't believe that we can sit and wait for someone else to do it. That's the crux of the issue, it's up to us.

Q. The nurse is in a unique position in that she is the one who has contact, immediate contact, with children. Associations or organizations can't really take a class of thirty children into their boardrooms to talk to them or observe them. How then can the pediatric nurse, or general duty nurse become more knowledgeable about the problems of child health?

Shirley: Her nursing education should have made her aware of what a healthy child is all about. I think nurses have also been introduced during the course of their education to a lot of community resources. They should have a pretty good idea of what is available in their community, of what could be available in their community and of what's needed there.

I think if the country has spent money to educate you as a nurse then you have a responsibility to give some of that back or have some commitment to your community to be the resource person in that community. You can be the resource person in many ways. A lot of nurses just lack confidence to do this when they've really got a lot of skills to offer.

I sincerely believe nurses can make a real contribution to the improvement of child health in this country, after all, there's a lot of manpower out there — or should I say nurse-power?



Shirley Post, *Registered Nurse, Toronto Western Hospital, 1955, received both her Bachelor of Science in Nursing Education (1967) and her Master's in Health Administration (1972) from the University of Ottawa. She was Director of Nursing at the Children's Hospital of Eastern Ontario, Ottawa until May of 1975 when she began her association with the Hospital for Sick Children Foundation.*





Behavioral Therapy:

Its application to reduce disruptive behaviors of the elderly in nursing homes

Nurses who care for the elderly in nursing homes and auxiliary hospitals have many goals. They provide for the health, recreational, social and emotional needs of their patients. They also strive to increase their patients' levels of self-care and self-respect. Unfortunately, because many patients exhibit disruptive behaviors — striking staff or other patients, throwing temper tantrums, lying on the floor in corridors, refusing to take medication and so on, these desirable goals cannot always be met. What nurses need, in addition to their specialized, medically oriented training, is training in a consistent strategy for handling these problems. Behavioral therapy provides this strategy.

Larry MacDonald

This article is adapted from a presentation at a Nursing Home Seminar on the Management of Mentally Retarded in Nursing Homes and Auxiliary Hospitals at the Bethany Care Centre in Calgary, Alberta on November 4, 1976.



When Mrs. A. lay down in the corridor and beat her hands and feet on the floor, a friendly visitor stopped to console her. A nurse and a nurse's aide also appeared and coaxed and cajoled her into getting up and going back into her room. Mrs. B., on the other hand, exhibited no disruptive behavior that day. She was left to her own devices to get on with her normal activities.

What really happened in this hypothetical case is that Mrs. A. was rewarded for her disruptive behavior. She received a great deal of sympathy and attention. Mrs. B.'s normal behavior was taken for granted. This anomaly lies at the root of behavioral therapy.

Behavioral therapy, well planned and conscientiously applied, can foster good relationships between nurses and their patients and increase the well-being of patients and the confidence of the nurses working with them. Used successfully, it can even cut down on your work load. But behavioral therapy cannot be taken lightly; it must be approached seriously and executed with attention to detail and with the full cooperation of all the staff concerned.

The importance of consequences

The basic assumption of behavioral therapy is that the causes of behavior are in the environment, not in the individual. The major cause of behavior *is what happens as a result of that behavior.*

A patient who is behaving appropriately seldom gets the attention of a busy nurse or nurse's aide. It's the patient whose disruptive behavior demands attention who gets attention. In other words, the squeaky wheel gets the grease. All patients enjoy the nurse's attention. If a patient does not receive this attention for appropriate behavior, he may attempt to obtain it by being disruptive.

A very good example of patients' behavior being influenced by attention comes from a project in the United States conducted by behavioral therapist Jack Michael. Dr. Michael was called in by a large general hospital to increase the number of elderly patients participating in physical therapy. The physical therapy took place in a large room with exercise equipment in the middle and chairs along the walls. Although patients were expected to exercise during the physical therapy periods, most were sitting in the chairs and only a few were exercising. Dr. Michael observed that most of the time of the physical therapists, all attractive young women, was spent in cajoling and persuading the seated patients to begin exercising. After a patient was up and exercising, the therapist quickly left him and went to encourage another seated patient to participate.

When examined in terms of consequences of behavior, this situation is a perfect example of the therapist "greasing the squeaky wheel." The therapists paid most attention to inappropriate behavior. In other words, the consequence of inappropriate behavior was attention.

To solve this problem, Michael suggested that the therapists begin to fuss over and pay attention to the men who made some effort at exercising and that they disregard the ones on the sidelines. Within two days, the men's exercising had increased to such an extent that the attending physician had to tell them to slow down lest they succumb to a heart attack from overexertion!

Note that in this example there was no discussion of "motivation." The behavioral therapist placed the emphasis entirely on the behavior itself and on arranging the consequences for more appropriate behavior.

The procedure sounds simple: control the consequences and control the behavior. While the principle is simple, its application is not. Behavioral therapy requires a great deal of thought and effort and consequences must be applied consistently and precisely. Inconsistent application of consequences can lead to anxiety and frustration for both the patients and the nurses who are required to care for them.

Steps in Behavioral Therapy

In starting any strategy of behavioral therapy the following six steps must be followed:

1. ***Define the target behavior*** — A "target behavior" is any observable behavior you want to change. Target behaviors must be defined so precisely that everyone can agree when they occur. Stay away from labels; for example, instead of saying that a patient is "depressed" or "aggressive," say that the patient remains in his room by himself a certain percentage of the day, or that he hits other patients a certain number of times each day. Usually, if you can count how often the behavior occurs, your definition is sufficiently precise.

2. ***Record baseline*** — A "baseline" is a record of how often the behavior occurs. Baselines are obtained for a number of reasons. Firstly, a baseline verifies that a particular behavior problem does exist; sometimes, nurses perceive a problem as being worse than it actually is. The charge nurse in a nursing home, for example, once told me that one of her patients was clogging the toilet almost daily. When careful baseline records were kept, the behavior was shown to be occurring once every four days, on the average, and usually when the patient was not allowed to attend his crafts class because of other behavior problems.

Secondly, a baseline is used for comparison purposes. Before you try to change behavior, you need to know how often that behavior is occurring. Comparing the frequency of behavior before and after attempts are made to change that behavior will allow you to determine whether your approach is successful.

Thirdly, a baseline will provide you the opportunity to observe the consequences of behavior. What happens after a patient misbehaves? After a patient throws a temper tantrum, for example, do nurses attempt to calm him down or do they ignore him? Usually, close observation and careful recording during the baseline period will give you some idea of the consequences that are maintaining the disruptive behavior.

3. ***Decide what consequences to use*** — Useful consequences for changing behaviors are generally things that the patient likes. Some patients like to spend time talking to the nurse; others enjoy cleaning up the cafeteria after meals, or setting the table before meals; some enjoy beer, some ice cream, and so on. These "likes" have to be determined separately for each patient. Sometimes you can ask the patient what he would like as a consequence for a particular behavior. Other times, you may have to determine what the patient likes by observation. These "likes" can then be used as consequences to increase appropriate behaviors.

4. ***Begin behavior-change program*** — In the majority of cases, you will begin a behavior-change program by providing the proper consequences for appropriate behavior and ignoring inappropriate behavior. Consequences should be applied *immediately* after appropriate behavior occurs and *every time* the behavior occurs. It is imperative in the early stages of a behavior-change program to ensure that the consequences are applied consistently.

How can you arrange for consequences to be applied *immediately* after a behavior occurs? For example, how do you follow a patient's behavior of "talking appropriately to other patients" with the consequence of "setting the table before meals?" The solution is to devise a "token system." These tokens can be given immediately following certain behaviors; the patient, of course, can trade in the tokens in exchange for something he likes. Nurses wishing to devise token systems should read some of the literature on the subject as there are many things to consider if success is to be achieved.

One final but important consideration must be understood. Behavior-change programs are not conducted without a patient's knowledge. On the contrary, the patient's or a guardian's opinion and informed consent should always be obtained before starting any behavior-change program. It is a patient's right to refuse to participate in the therapeutic process; if he refuses, the program

should not be conducted. If the patient is able to communicate and understand, explain to him that you are setting up a program to help him get along better with other patients, spend more time with other patients, bathe more frequently, or whatever is seen as a desirable goal for that particular patient. Then explain the program: if he behaves one way, such and such will happen; if he behaves another way, something else (or nothing) will happen. Sometimes, you can even write a contract stipulating that the patient agrees to behave in a certain way while the nurse agrees to provide certain consequences. But remember, it is entirely unethical to carry out a program without the informed consent of either the patient or, if the patient is judged incompetent, his guardian.

5. ***Evaluate success*** — If after several days of applying consequences for appropriate behavior, you find that the target behavior is decreasing in frequency relative to baseline, then continue the program until the behavior is at the desired level. If the behavior is not changing, then you must re-examine the program to find out what went wrong. A change in the consequence or in the technique in administering the consequence may be required before the target behavior will change.

6. ***Maintain the appropriate behavior*** — Once the appropriate behavior is occurring at the desired level, you will want to decrease the number of consequences. This procedure requires a gradual and systematic shift from a situation where consequences are applied every time the appropriate behavior occurs to a situation where they are applied less frequently. Although many consequences are required to change behavior, fewer consequences are required in order to maintain behavior.

In addition to these six essential steps, keep careful records of the frequency of inappropriate behavior throughout all phases of your behavior-change program. This will enable you to determine exactly what is happening to that behavior at any point in time. These records will hold you accountable for your actions. If you have been consistent and used the proper consequences, your records will show a decrease in disruptive behavior. On the other hand, if you have not carried out a precise and consistent program, your records will show no change in the behavior.

These basic features of behavioral therapy, if implemented with thought and consideration for the dignity of patients, can go a long way toward eliminating the disruptive behaviors of most elderly patients in nursing home settings.

Some Problems

Of course, when any treatment strategy is implemented problems occur. Behavioral therapy in nursing home settings is no exception. A variety of problems must inevitably be faced.

- *Attitudes of Staff* — Many nurses excuse the misbehaviors of elderly patients, particularly those who have been diagnosed as senile, mentally ill, mentally retarded or minimally brain dysfunctioned. What these nurses fail to realize is that their expectations of what a patient *can* do influence what that patient *will* do. If you have low expectations of a patient because of his diagnostic label, that patient will respond accordingly and you can expect to see dependency behaviors and misbehaviors occurring frequently. These attitudes occur to a greater degree among staff in nursing homes where behavioral therapy programs have not been implemented. Usually such homes have many "squeaky wheels."

Another problem is that some nurses see behavioral therapy as being too mechanical and too objective. Actually, these features should be considered arguments supporting the use of behavioral therapy as they make nurses responsible and accountable for their actions and for the behaviors of their patients.

Finally, staff may complain that behavioral therapy requires additional work for an already overworked staff. It's true that designing behavior-change programs, recording behaviors, and delivering consequences consistently takes a great deal of time and effort; however, in the long run, workloads tend to decrease as patients become more self-reliant and less troublesome.

- *Lack of Support* — For behavioral therapy to be successful, it must be sanctioned at all levels within the nursing home. Administrators, supervisors, and front-line workers should be in close agreement that the approach is a viable treatment strategy. Such broad concurrence is, of course, the ideal and is not likely to occur in every nursing home; however, my experience has been that greater support increases the success rate of behavioral therapy programs. One staff member in disagreement with this treatment strategy can unwittingly sabotage any behavior-change program.
- *Lack of Consistency* — Related to the issue of support is consistency in applying consequences. This is very important if behavior changes are to be expected. There are many reasons why consequences are not applied consistently. Some nurses or nurse's aides are simply not cooperative or they are apathetic towards trying anything new. Shift changes may cause disruption in a program. Or, nurses may be overworked or simply inattentive to the behaviors of their patients — particularly appropriate behaviors. Some nurses and nurse's aides are natural therapists: concerned and interested in their patient, enthusiastic, sympathetic, and most of all, consistent. Others are not. However, even the most disgruntled nurses can be encouraged to assume a more positive role if consequences are provided to them by their superiors and colleagues at appropriate times. Remember, patients aren't the only ones whose behaviors can be changed through the proper use of consequences.

Some Benefits

In spite of the problems you are sure to encounter when using behavioral therapy, the benefits will be worth the effort.

- *Increased positive contact between nurses and patients* — When nurses provide more and more consequences that patients like, nurse-patient relationships will become more positive. The treatment strategy of behavioral therapy focuses attention on appropriate behaviors instead of inappropriate behaviors; this decreases the number of negative contacts. The result is an improvement in the overall emotional climate in the nursing home.
- *Increased well-being of patients* — Patients who engage in disruptive behavior to

gain staff attention do not have a high regard for themselves nor do they feel very content with their life in general. Studies on behavioral therapy programs generally show that patients not only become less disruptive, but show a general improvement in initiative, responsibility, and social interaction. This outcome is entirely predictable. Behavioral therapy requires the patient to put the burden of responsibility for appropriate behavior on himself, thus increasing self-respect.

- *Increased staff confidence* — Very often, nurses confronted with disruptive behaviors are at a loss what to do. Behavioral therapy provides them with a plan of action. It's objective and it works. If it doesn't, the nurse can determine why. As programs are implemented and patients begin to behave appropriately, the nurses are rewarded for their efforts, thus increasing their confidence in their ability to meet the needs of patients.
- *Decreased work load* — Although alluded to earlier, this benefit should be reiterated here. As patients become more well-behaved and more self-sufficient, they require less supervision. Instead of cleaning up messes, delivering reprimands or arguing with patients, nurses can spend more time with their patients in a positive fashion.

Conclusion

Working out a strategy of behavioral therapy takes time and its application requires patience and attention to detail. The successful application of behavioral therapy* brings benefits to both nurses and their patients. Nurses will have more time and energy to devote to their real goals — providing for the physical and emotional needs of their patients and helping patients increase their own levels of self-care and self-respect. Patients will find their rewards in their growing self-esteem and self-sufficiency.

The author emphasizes that this paper is not intended as a working manual in behavioral therapy. Additional knowledge and expert supervision are required in order to establish these programs successfully.

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Larry MacDonald *(Ph.D., Psychology, University of Wisconsin) is director of Behavior Management Services, a branch of Services for the Handicapped in Edmonton, Alberta.*

He has worked as a research psychologist at the Wisconsin Medical College and acted as a private consultant to nursing homes in the U.S.





Helping young ostomy patients help themselves

Photo Courtesy of Centre Hospitalier Maisonneuve Rosemont de Montréal

Sandy Morrison is now a happy and well adjusted six year old. Over a year ago she came to our hospital for the surgical construction of an ileal conduit. As Enterostomal Therapist I was familiar with the problems I had to deal with in teaching adolescents and adults about stoma care, but how was I to teach a five-year-old child about it?

Hildegard Tisdale

We began counselling Sandy's parents, and especially her mother, approximately one month prior to the child's hospitalization. At this early stage Sandy's mother was very anxious and reluctant to have her child go through the trauma of ostomy surgery. During my first visit with Mrs. Morrison I realized I needed extra help.

I called upon the services of our pastoral care unit, social services, psychotherapy and the pediatric nursing staff. Together we formed a team and each member of our team visited Sandy's mother daily for one week. At the end of that week she talked openly about the upcoming surgery and asked many, many questions. Working as a team we helped Mrs. Morrison come to understand and accept her daughter's ileal conduit surgery.

Even so, I was troubled as to how I would approach Sandy. This concern led me to arrange a meeting between myself and the Pediatric Head Nurse. There we decided to try a new approach to the problem. We called our solution Ostomy Play Therapy; attempting to teach the child ostomy care through play.

All through the parental counselling I had no idea what my little friend looked like or how she might react to our approach. On Sandy's admission to our pediatric unit I found she was a sweet, blond-haired, blue-eyed little girl who was soaked in perspiration as she was moving only with the aid of a walker.

As therapist my first goal was to reduce Sandy's fear and give her an understanding of what was to happen to her and why.

Sandy was scheduled for an ileal conduit to overcome urinary incontinence caused by a neurogenic bladder due to a myelomeningocele. We had one week before surgery, so we got started on our planned project right away.



Photo Courtesy of Health Sciences Resource Centre, Winnipeg

Play Therapy

I gave Sandy a doll that she decided to call Susie. On the doll's abdomen I had glued a stoma. I also gave her several ostomy pouches, micropore tape, a night drainage bag, syringes, surgical sponges, tubing, crayons and, of course, the ostomy coloring book "All About Jimmy."

Carefully I explained what each item was used for and why we used it. At first Sandy was reluctant to handle the equipment, but, on my second visit she was more relaxed and ready to play with it.

Repeatedly I explained all the items and their functions. During this time I used the doll as a model and then transferred my actions to the child. The floor nurses reinforced my teaching by playing with Sandy and her doll at other times in the day.

On the third morning of therapy Sandy was ready to tell me all about her doll's surgery. She gave reasons for giving our "pretend patient" injections, why she was wearing a stoma bag, and having tubes go into her arm (I.V.). Sandy really seemed to understand what was happening.

By the fourth morning Sandy had mastered the pouch opening and closing device and she knew the importance of closing the valve after emptying the pouch.

Her stoma site was marked and Sandy went off to the O.R. I affixed a post-op pouch to the stoma in the operating room. A small catheter was left in the stoma. A straight drainage bag was connected to the catheter to facilitate unobstructed drainage of urine.

After surgery the operating and recovery room staff told me they had never seen such a well-prepared child. Not once did my young friend pull at any of the tubings or object to anything that was happening to her.

Post-op

On the first post-op day Sandy greeted me smiling and already sitting in a chair. She was still connected to intravenous feeding and bedside drainage. I questioned her about all the tubes and she told me each one's purpose. Sandy said she didn't mind them after all, they were going to make her feel better.

I checked her stoma, then her urinary pouch for leakage, and explained my actions to her. Now I brought the doll back into the picture. I asked Sandy to check the doll's pouch for leakage, just as I had checked hers. Sandy went through this task without hesitation.



On the second post-op day my little patient greeted me with "my baby's bag is leaking." Now that was serious business. We discussed our course of action and soon corrected the situation. We bathed the doll, carefully dried the stoma site, laid down a skin barrier, attached a new stoma bag and picture frame taped the area with micropore tape. Sandy did ninety percent of this work. Oddly enough it was not until after the doll was "dry" that I got an opportunity to ask Sandy if she was alright. She assured me she was.

Sandy improved daily and was ready for discharge three weeks after surgery. At that time I measured her for a semi-disposable appliance. The stoma was quite edematous post-surgically and therefore we had continued to use post-op pouches.

Sandy's parents were taught how to care for the stoma, how to assemble and drain the pouch, and how to clean and care for the equipment. All this was done with Sandy's participation. We also gave her parents detailed written instructions to take home with them. Family education was vitally important for Sandy because the Morrisons lived almost 250 miles from the hospital.

The semi-disposable (permanent) appliance arrived at the hospital during the patient's fifth post-op week. Unfortunately Sandy had suffered a setback and had to be readmitted to hospital with a bowel obstruction right around this time.

Follow-up

A couple of days after emergency surgery, I showed my friend the new pouches and how they were assembled. Sandy was very eager to try those nice pink and blue pouches. She picked a pink pouch, we applied it and it stayed affixed for seven days.

Sandy and her parents made several follow-up visits to the hospital after the surgery. These visits showed both Sandy and her parents were happy and well-adjusted to the ileal conduit, its care and management. Recently, Sandy started school and her teacher lets her leave the classroom to empty the pouch whenever necessary.

Sandy, the youngest in a family of four daughters, is the only child with a serious medical problem. But this doesn't prevent my young friend from active play with her sisters or her friends.

As an Enterostomal Therapist, Sandy was my first experience with a very young patient at a possible teaching age. Happily our use of play therapy succeeded and Sandy has been able to adjust well to her stoma. Ostomy play therapy has since been used on other young ostomy patients in our hospital with equally satisfying results.



Hildegard Tisdale, *R.N.A., E.T., the author of "Helping Young Ostomy Patients Help Themselves," graduated from the Ottawa Civic Hospital School of Registered Nursing Assistants in 1973. Immediately after graduation she attended the Harrisburg General Hospital School for Enterostomal Therapists in Harrisburg, Pennsylvania. She was certified in March, 1974.*

Hildegard worked briefly at the Ottawa Civic Hospital and the Ottawa Ostomy Centre on a part-time basis. Then, late in 1974, she moved to Thunder Bay where she has been working as a full-time Enterostomal Therapist at St. Joseph's General Hospital. She is the only Enterostomal Therapist in northwestern Ontario and therefore serves all ostomates in that region. She also acts as a consultant to all hospitals and community services in northwest Ontario.

Twice a year Hildegard joins a Mobile Team and conducts Ostomy Clinics and educational services in other northern centers. She is an active member of the Thunder Bay Ostomy Association and the United Ostomy Association.

Clinical Wordsearch

Answers

Puzzle no. 7 (appears on page 39)

1 Hyperalimentation
2 Ileum
3 Sigmoidoscopy
4 Gallstones
5 Liver
6 Jaundice
7 Pylorus
8 Hydrochloric Acid
9 Banana
10 Mesentery
11 Hepatitis
12 Pancreozymin
13 Peristalsis
14 Volvulus
15 Vagus
16 Bowel
17 Oral
18 Enzymes
19 Mucus
20 Hernia
21 Bernstein
22 Pill
23 Duodenum
24 Chyme
25 Occult Blood
26 Ulcer
27 Colitis
28 Gastritis
29 Appendectomy
30 Bolus
31 Gland
32 Oddi
33 Nervous
34 Fats
35 I.V.C.
36 Faeces
37 Tube
38 N.P.O.
39 Lait
40 Tongue
41 Solids
Hidden Answer: Fitness prevents fatnes

Privacy: the forgotten need

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge ... to do this in such a way as to help him gain independence as rapidly as possible when independence is achievable This aspect of the work of nurses they initiate and control; of this they are masters". [1]

Ellen D. Schultz



Since the beginning of the history of "nursing", assistance to the individual has been considered as being at the core of all nursing activity, regardless of the setting or nursing function performed. The first step in this care-giving process is, of necessity, the identification and determination of the needs of the person who will receive this care. No one would presume to deny a healthy person the need for and right to privacy. Yet this is a need that is too often overlooked in planning the nursing care of institutionalized individuals, particularly those in a psychiatric care setting.

Nursing process involves diagnosing individual needs and their various fluctuations and from this diagnosis planning an individual treatment approach that utilizes the complete environment. When writing about the therapeutic milieu, the subjects that authors in the field of nursing most often include are ones such as occupational and recreational activities, the setting of patient goals, locked or unlocked wards and patient governments. There can be no arguing the fact that these are significant areas of interest. But so is privacy, and yet this is an area that is not adequately dealt with in nursing literature or in our hospitals.

"Privacy implies both the freedom to remove one's self from the tensions of interacting with others and the freedom to interact with certain people without having to respond to the intrusions of others." [2]

In other words, privacy offers freedom from the pressures of togetherness.

The overall function of privacy is to increase the number of options available to the individual so that he can behave in ways appropriate to his particular purposes.

People need privacy in order to maintain psychological, spiritual and physical well-being. Paul Rosenblatt suggests people seek privacy for the following reasons:

— to protect others
— to avoid punishment
— to protect ourselves from the threat of evaluation
— and to fulfill modesty norms.[3]

Sidney Jourard describes privacy as a way of seeking change. A person usually needs to leave the presence of other people in order to depart from the way he has always been when with them.

"Being with" other people suggests a contract from one person to act and react before others the same way he always has.[4] Other people can serve to chain a person to his present identity and make any amount of deviation from this very difficult.

An individual can find privacy "backstage" or away from the interfering eyes of the public. For it is here that a person can "get things together," it is here that all public rules may be violated.

Privacy in our Institutions

In the past lack of privacy has been used in institutions to control behavior or to encourage conformity to assigned roles. But one of the results of lack of privacy can be both patients and those caring for them treating witnesses (other people) as "non-persons." We may carry out, in front of others, activities traditionally done in an atmosphere of privacy. This kind of behavior can only result in a defeat of the milieu's goal of increased socialization and improved interactions.

In order to get an idea of just how patients feel about the issue of privacy I prepared a questionnaire and presented it to fifty hospitalized psychiatric patients. The results are presented below.

These responses would seem to indicate:

- most patients find it easier to talk to a staff person when privacy is provided
- most patients prefer a private or double room
- most patients have some time during the day when they want to be alone
- most patients surveyed rated their need for privacy as either average or high.

Increased privacy can be provided in our institutions by modifying the structure of the living environment (Psychiatric Unit). Conference rooms which can be used for nurse-patient interactions should be an important part of this environment.

New units could be constructed with primarily private and double rooms. These rooms must themselves offer privacy. They should, for example, have curtains on the windows and doors that patients can close.

There are ways to increase the amount of privacy available to patients without making major structural changes to the environment. A unit policy might be established that discourages patients from going into other patients' rooms and, instead, encourages socialization in lounges. For patients in semi-private rooms, arrangements can be made between the roommates for them to use the room alone at specific times.

"The posture, position and location of the nurse can contribute to or detract from the nursing ethic of private or confidential conversation. If the nurse sits or stands closely to the patient, facing them for ease in vision and hearing, then the one-to-one situation is enhanced and the sense of privacy assured."[5]

Unfortunately, a therapeutic milieu that offers privacy also offers the opportunity for seclusion. This puts greater responsibility on the hospital staff. They must encourage a seclusive patient to socialize. Nurses must be even more aware of patients' feelings, particularly depressed patients with suicidal tendencies. This necessitates adequate nursing staff and a freeing of the nursing staff from nonessential activities.

Patients have indicated a need for privacy and cooperation from staff is required to make the necessary milieu changes. The nurse holds the distinction of being the one person who can "make the most direct and unique contribution to milieu therapy."[6]

PATIENT QUESTIONNAIRE

Question	Number of Responses		
1. It is easier to talk to a staff person when ...	Privacy is Provided 48	Other People Are Around 1	Makes No Difference 1
2. Which type of room would you prefer if the cost was not a concern?	Private [illegible]	Double 20	3-4 Bed 8
3. Does this statement apply to you? "There are times each day that I prefer to be alone."	Yes 45	No 5	
4. How do you rate your need	Low	Average	High

*The author of "Privacy : the forgotten need," **Ellen Schultz,** is currently an Instructor with the School of Nursing at the University of Minnesota in Minneapolis. She graduated with her Bachelor of Arts in Nursing from the College of St. Scholastica, Duluth, Minnesota. She received her Master's of Science in Nursing from the University of Minnesota where she specialized in psychiatric nursing. Immediately after graduation Ellen worked for a time as Psychiatric Head Nurse at Mounds Park Hospital in St. Paul, Minnesota.*

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EXPANDED ROLES IN RESPIRATORY NURSING

The 'expanded role of the nurse' is a phrase that has gained considerable popularity, a concept that has received a good deal of attention in both nursing education and literature. But in concrete terms, what does it mean for nurses, their patients, and other members of the health care team? In the articles that follow, two Canadian nurses describe their individual experiences with the development of expanded roles in respiratory nursing.



The Respiratory Nurse Clinician for Quality

Ella MacLeod

For several years, the nursing department at Prince Edward Island Hospital in Charlottetown had been requesting approval for the position of a nurse clinician. Finally, the support of our medical staff and the Board of Trustees gave us the opportunity we had been waiting for — the chance to develop a quality care program in respiratory nursing. Since the beginning of our program, the acclaim for our service from physicians, nurses, patients and community members has been so great that we feel that other hospitals might like to share in our experience.

From the beginning of our program, we were fortunate in having a nurse on staff with the education, experience and expertise necessary for giving care to patients with respiratory disease. She had the teaching ability and initiative necessary for helping other nurses and patients, and was energetic enough to devote additional time to establishing rehabilitative programs and do research studies. We also had an internist on staff who was keenly interested in respiratory disease, and wanted to set up a respiratory department.

"Starting from Scratch..."

In our small hospital, it took major reorganization and cooperation to begin a comprehensive new program. We got underway by finding a 'niche' that could be identified as the respiratory room. The next step lay in assembling all our hospital respiratory equipment, taking inventory of our supplies, and studying the many types of respiratory diseases treated at our hospital, together with the modes of treatment.

When this was accomplished, we began to write out our philosophy and decide upon the objectives of our program. Working slowly, we read current literature, gathered ideas from other staff members, and experimented to establish the most suitable working hours for a program of optimum effectiveness. Finally, we drew up a job description that outlined working relationships and established hours of work. We defined the respiratory care unit as: "a separate unit established within the hospital for the purpose of providing a high quality of care to patients with respiratory problems on an in-patient, out-patient basis", and the respiratory care clinician as: "a person who has acquired background knowledge, expertise, and experience in caring for patients with respiratory problems; is skilled in techniques for meeting emergency situations; provides for improvement of nursing care through teaching and assisting staff, and works under the guidance of physicians in charge."

In order to fulfill this description and meet our objectives, the clinician's role was considered in four areas:

- her functions in promoting patient care
- her role in teaching
- her job as manager of a department
- her expectations for her own self-development.

Patient Care and Teaching

The main concern of our program is with patient care and teaching. The nurse clinician makes daily visits to all in-patients receiving respiratory therapy, either helping with care and treatments herself, or supervising the patient's nurse in planning and giving care. She visits patients on continuous ventilation, assesses the progress of patients being weaned from the ventilator, monitors patients receiving I.P.P.B. therapy, and does chest

The Clinical Nurse Specialist: An Individual

Lee Robinson

In the past few years, the role of the clinical nurse specialist has claimed the attention of both nursing education and our professional literature. Experience with this new role however, has occurred largely in the United States; it remains a relatively new concept in Canada. It was only in April, 1976 that the Registered Nurses Association of Ontario produced a comprehensive statement on the clinical nurse specialist.[1] Because it is so new, there is still variation in the interpretation of the role. Documentation of individual experiences with this role is important; through it we can fully explore its contributions to patient care. The experience of a clinical nurse specialist in the Regional Chest and Allergy Unit of St. Joseph's Hospital in Hamilton., Ontario is described here.

The Regional Chest and Allergy Unit includes the practices of four chest physicians. These physicians practice in a newly opened out-patient unit which provides care to respiratory patients. A clinical nurse specialist has worked with the group since July, 1973. There are three broad responsibilities in the position: patient care, education and research.

1. Patient Care

For the clinical nurse specialist, the primary area of responsibility lies in the follow-up of close to 100 patients with chronic respiratory disease, usually chronic bronchitis, emphysema, or asthma. Patients are referred to the nurse by the four chest physicians. The pattern of referral is illustrated in Figure 1. Sometimes the nurse supervises the total out-patient respiratory care of the patient; sometimes the physician takes on this responsibility while the nurse provides educational and supportive care: usually, there is a give and take of responsibility depending on the patient's needs. In all instances, there is a close working relationship between the patient, nurse and physician.

Though planned home and unit visits for the purpose of clinical assessment and/or therapeutic interventions do occur, perhaps the most significant contribution the nurse makes to both patients and families is immediate accessibility. The nurse's use of a long-range bell-boy insures that the patient will be able to get in touch with her according to his needs. The nurse is prepared to help the patient who calls her by:

- giving advice regarding straightforward adjustments to his therapeutic regimen
- making a home visit or arranging a unit visit if this seems necessary
- organizing prompt attention when a significant clinical problem arises
- arranging additional services such as day care, home care, and social assistance
- listening to all the patient's concerns, however small, so that his anxiety related to health problems is minimized.

The nurse's case load varies over time as patients and families are *all* at various stages in learning to live comfortably with their disability. The goal is to make the patients as independent of the health care system as possible. Once patients have learned to monitor their conditions skillfully and to adjust their treatment appropriately, close follow-up can be discontinued. When a patient has demonstrated appropriate self-management of disease related problems and has achieved a life-style that is not unnecessarily hampered by his disability, then nurse-patient contacts are markedly reduced.

Care

physio, suctioning etc.

She is also responsible for the newly admitted respiratory patient, for beginning his treatments and helping to plan his program of care. She works with the physiotherapist in teaching patients prior to chest surgery, and visits these patients post-surgery to assess their condition and help with their care.

Education of the patient and his family is seen as a very important factor in health promotion, and for this reason, the nurse clinician is very involved in helping the patient and his family to understand his disease. She instructs the patient in rehabilitative measures, teaches him self-care and management of his own treatments, and helps him to understand ways in which he can prevent further problems. She is responsible for teaching families to help with the patient's care at home. Families are much more fully prepared to cope with the problem of the patient's illness when they understand more about the disease and the way in which it affects the patient and learn something about the equipment and drugs used by the patient with the consistent encouragement of the nurse clinician. When necessary, the clinician also makes arrangements with the public health nurse for follow-up care.

In-patient therapy is not the only responsibility of the nurse clinician. An important component in the establishment of our program was an out-patient chest clinic for patients suffering from chronic obstructive lung disease. Here the nurse clinician works closely with the physiotherapist. The goals of the program are:

- to improve the quality of daily life for patients by lessening breathlessness and improving their level of physical activity
- to reduce the number of hospital admissions necessary to the patient.

The out-patient program includes instruction in chest clearing, breathing retraining, and patient education about the disease itself; it also permits ongoing assessment and evaluation of C.O.L.D. patients. This part of our program has great value in improving patient morale. The patient's fear of his symptoms has been largely overcome by the emotional support that is provided through the creation of a "club" environment, where patients learn from each other.

Working with Staff

As quality patient care is our aim, all staff members are taught by the nurse clinician to develop skills in nursing the respiratory patient, and staff teaching takes up a good part of the clinician's day. In addition to the daily individual teaching and supervision of staff, she participates in workshops, ward clinics and seminars and has a planned educational program in the school of nursing, for nurses from other hospitals, and for nurses taking refresher courses. She has also had workshops with maintenance men and orderlies to teach them safety measures in handling equipment such as oxygen or compressed air, and has provided educational programs for hospital chaplains and medical interns.

Continuity is a must for quality care. To promote continuity, the nurse clinician chaired a committee that developed standard nursing care plans for patients with pneumonia, asthma and chronic obstructive lung disease. She also developed an educational teaching plan for the rehabilitation of C.O.L.D. patients and established with the physiotherapist a preop and postop course for surgical patients.

Perspective

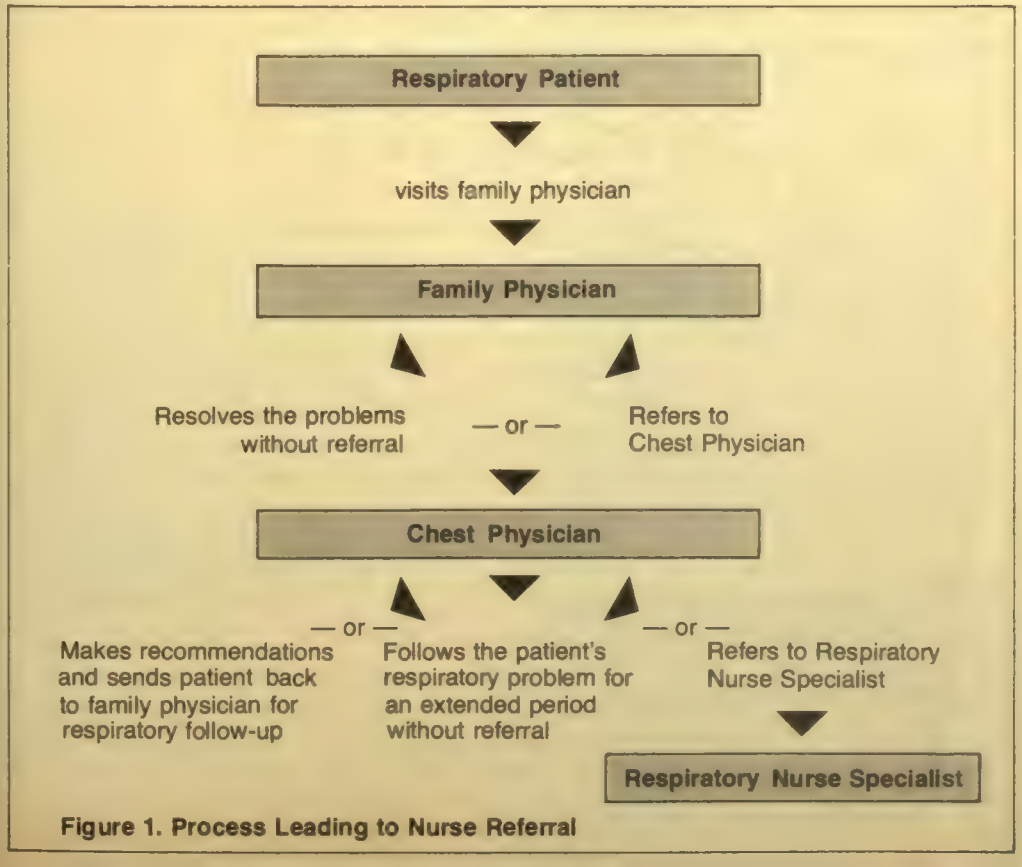


Figure 1. Process Leading to Nurse Referral

2. Education

The second aspect of the role of the nurse involves educational input to meet the needs of other professionals and students. Some of the educational responsibilities are informal, for example, the sharing of experience in the care of specific patients. Other responsibilities are more formal.

Informal responsibilities include discussions with others providing care to respiratory patients familiar to the nurse. For example, joint home visits are made with community nurses who visit the most severely limited patients on a regular basis. This allows the patient, the respiratory nurse specialist and the community nurse to work closely together in helping the families. In this way, a three-way dialogue is established to ease communication whenever a problem arises. It also provides the respiratory nurse with an opportunity to share with the community nurse some of the clinical assessment skills and therapeutic concepts which are specific to individual patients.

More formal educational responsibilities include participation in workshops, seminars, or conferences. There are an average of three

The nurse clinician also participates with the physician in new methods of care and treatment. She worked closely with the doctor, for example, in establishing safer controls and assessment of patients by exercise stress testing, so that rehabilitative activities would not exceed the patient's cardiac tolerance.

In September 1975, when Beclovent* inhalers became available in Canada, the clinician, under the guidance of the physician, started a study on their use. Fourteen carefully selected out-patients were closely observed and evaluated for the effectiveness of this new form of steroid.

Expired flow testing and 'stop smoking' clinics are added to the list of duties performed by the nurse clinician. She has established a library for books, journals and reference material at our hospital. Each month she submits a summary of her work to the director of nursing to be included in the report to the Board of Trustees.

We are proud of our program. In addition to providing comprehensive respiratory care and teaching for both staff and patients, we feel that our nursing department has made an important and effective effort towards prevention, in a time when health care trends swing towards health promotion and prevention of illness.

Ella MacLeod *(R.N., St. John General Hospital School of Nursing; B.N., McGill University; M.S., Boston University) author of "The Respiratory Nurse Clinican for Quality Care," has recently retired as Director of Nursing of Prince Edward Island Hospital, to become the director of public health nursing with the provincial government in Charlottetown, Prince Edward Island. She has been a teacher with the St. John General Hospital School of Nursing, St. John, New Brunswick, a consultant with the Department of National Health and Welfare, and the first nurse member appointed to the P.E.I. Civil Service Commission. Ella MacLeod is a former president of the Association of Nurses of Prince Edward Island and past CNA board member.*

** Beclovent Inhaler is a registered trade mark of Allen and Hanburys.*

The photo on page 35 shows Etta Connolly, R.N., Respiratory Nurse Clinician, and Mabel Davies, M.C.P.A., Physiotherapist, teaching and supervising an I.P.P.B. treatment taken by Phillip Henderson, a patient with extrinsic asthma.

or four requests for participation in organized educational projects each year. These are usually accepted. In addition, a clinical appointment with McMaster University School of Nursing allows the nurse to contribute to the learning experiences of several undergraduate and graduate students each year.

3. Research

Formal studies have not been undertaken up to the present time, but several co-operative efforts are beginning to materialize within the Regional Chest and Allergy Unit and the School of Nursing at McMaster University. It is hoped that some studies can soon be undertaken to look at the special needs of the chronically disabled respiratory patient.

Summary

Clinical nurse specialists are a relatively new breed of practitioner on the Canadian health care scene. The role described here has made a knowledgeable respiratory nurse specialist available to patients, other professional colleagues, and students. Feedback from all of these sources has been favorable and the position has certainly provided a great deal of professional satisfaction to the nurse.

Lee Robinson *(R.N., Winnipeg General Hospital School of Nursing; B.N., University of Manitoba; M.Sc.(A), McGill University), author of "The Clinical Nurse Specialist: An Individual Perspective" is presently Clinical Nurse Specialist for the Regional Respiratory Programme at St. Joseph's Hospital in Hamilton, Ontario, and Assistant Clinical Professor at the McMaster University School of Nursing. Her previous nursing experience includes positions as clinical instructor in medical-surgical nursing at the Winnipeg General Hospital School of Nursing and at the Massachusetts General Hospital School of Nursing in Boston, Massachusetts.*

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Clinical Wordsearch no. 7

This is another in a continuing series of clinical word search puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has three words. *(Answers page 32).*

H E P A T I T I S S S I T I L O C
Y Y R E T N E S E M T E M Y H C S
D B P E R I S T A L S I S B D S T
R E I E T A O M N S I J N O O O Y
O R L B R I R U S P D A N L O L P
C N L O F A A E Y P D U E U L I O
H S D W G A L L S T O N E S B D C
L T U E E R O I F F A D M A T S S
O E O L E R R V M A N I U I L S O
R I D S U C E E S E A C C N U E D
I N E S G V C R U C N E U R C M I
C E N O N I L E G E A T S E C Y O
A B U P O V U O A S B T A H O Z M
C U M N T N E R V O U S E T I N G
I T A P P E N D E C T O M Y I E I
D S I T I R T S A G G L A N D O S
P A N C R E O Z Y M I N F A T S N

1 Parenteral nutrition often administered into the subclavian vein. *(17)*
2 Not to be confused with ilium. *(5)*
3 Procedure during which the distal portion of the colon can be examined. *(13)*
4 Calculi which form in the gallbladder. *(10)*
5. A large lobed abdominal organ. *(5)*
6. A condition characterized by yellow sclera and skin. *(8)*
7 The lower third of the stomach. *(7)*
8 Chemical of the gastric juice which lowers its pH. *(12, 4)*
9 High potassium monkey food. *(6)*
10 Fold of peritoneum attaching the intestine to the posterior abdominal wall. *(9)*
11 Inflammation of the liver. *(9)*
12 A hormone of the duodenal mucosa which stimulates the secretion of pancreatic enzymes to the gut. *(12)*
13 Contraction and relaxation of the muscles of the intestine, resulting in propulsion of the contents. *(11)*
14 Intestinal obstruction caused by looping of the bowel. *(8)*
15 The tenth cranial nerve. *(5)*
16 The intestine. *(5)*
17 Pertaining to the mouth. *(4)*
18 Organic compounds found in the body, many of which act as catalysts. *(7)*
19 Its chief constituent is mucin. *(5)*
20 Inguinal, hiatus, or umbilical. *(6)*
21 Test to diagnose esophageal reflux; no relation to Leonard. *(9)*
22 Sometimes bitter to swallow. *(4)*
23 The first portion of the small intestine. *(8)*
24 Material produced by the action of gastric juice on ingested food. *(5)*
25 Lady Macbeth would surely have welcomed this to hide the most obvious evidence of her crime. *(5, 6)*
26 An erosion which may be cratered. *(5)*
27 Inflammation of the colon. *(7)*
28 Inflammation of the stomach. *(9)*
29 Removal of the subsidiary addition to a book or document. *(12)*
30 A quantity of food entering the esophagus in one swallow. *(5)*
31 May be exocrine or endocrine, organ which secretes a specific substance. *(5)*
32 Oddly enough, it's a sphincter. *(4)*
33 Many functional diseases have a.....or psychological aspect to their etiology. *(7)*
34 The last food substance to leave the stomach; now if it would just leave the hips! *(4)*
35 Intravenous cholangiogram. *(3)*
36 Waste products of the digestive process. *(6)*
37 Nasogastric or levine. *(4)*
38 Nil per os. *(3)*
39 Frenchmen with ulcers drink it. *(4)*
40 Best kept in check or cheek. *(6)*
41 Unlike liquids can't be drunk. *(6)*

Names and Faces

CNJ talks to

Hallie Sloan

It's a far cry from nursing in the Yukon to coordinating activities at the Canadian Nurses Association but that is part of the route that **Hallie Sloan** has taken in her professional life since her graduation from the Vancouver General Hospital School of Nursing. Having lived in almost every part of Canada while working as a nurse for the Armed Forces, and later, settling in Ottawa as Director of Nursing, Canadian Forces Medical Services, Hallie came to CNA in 1968 to coordinate the ICN Congress held in Montreal the following year. With this year's ICN Congress held last month in Tokyo, she was once again involved in preparations for an international nursing rendezvous. This time, her responsibilities focused on recruiting well-known Canadian nurses to participate in panel discussions relating to current nursing issues — a task which she completed early in the Spring.



As nursing coordinator, one of Hallie's main roles deals with the secretariate function of the association — a task she shares with many others at CNA. These functions include preparing executive committee reports, reports for board meetings and the CNA annual and biennial meetings. Organizing meetings, inviting people to attend, preparing agendas and collecting background material is no simple task ... Besides this, she is often involved in trying to find nurse experts who will provide nursing input and represent your association on various government and non-governmental committees. Such committees deal with issues relevant to nursing such as child abuse and neglect, drug information, and family planning for example.

Part and parcel of her job is answering letters from nurses who wish to take part in the ICN Nursing Abroad program. In Canada, the program is set up to help those Canadian nurses who wish to work or study in another country — and that includes nurses seeking employment in the United States. Since CNA is aware of those states in the U.S. which have reciprocity with Canadian registration, Hallie advises nurses going to the U.S. or to any country to make use of the Nursing Abroad program rather than going through employment agencies.

On the international scene, Hallie's involvement with CNA's nursing projects funded by the Canadian International Development Agency (CIDA) is going to be one of her favorite duties. Until recently, this function was managed entirely by Dr. Mussallem, executive director of CNA. Last year, CNA was involved with such programs as: providing Nursing Unit Administration Courses in Zaire, Haiti, Botswana, and until recently, Lebanon; helping the University School of Nursing in Havana, Cuba, set up library services, AV aids and other teaching aids; sending film strips to a nurse in the outback of Malawi; developing regional Nursing Examinations in Commonwealth Carribean Schools of Nursing; training nurses at the supervisory level to work in rural communities in Botswana; and other projects. These services are carried on in the name of all Canadian nurses to assist in the development of their fellow nurses around the world.

All in all, the job of nursing coordinator at CNA provides a full and interesting day for Hallie and as she states, "the best part is meeting so many fantastic nurses from all across Canada."



Verna Huffman Splane, past Principal Nursing Officer for Health and Welfare Canada has been elected 2nd Vice-President of the International Council of Nurses at the 16th Quadrennial Congress held in Tokyo recently. She has just completed a four-year term as 3rd Vice-President of ICN and is currently a special lecturer on nursing issues in national and international health at the University of British Columbia School of Nursing.

Splane's nursing career has included many national and international assignments for which she has received numerous awards and honors from her nursing colleagues.

Alice J. Baumgart has been named Dean of the School of Nursing at Queen's University, effective September 1, 1977. She succeeds **Dean E. Jean M. Hill,** who is retiring after serving in this capacity for nine years.

Right now, Baumgart is completing her doctoral studies at the University of Toronto. She received her M.Sc.(Applied) from McGill University and her B.Sc.N. from the University of British Columbia.

Baumgart has previously worked on the faculty of the School of Nursing and Division of Interprofessional Education at the University of British Columbia. She has acted as a consultant in basic nursing education to other institutions in various parts of Canada.

Her academic research activities have focused on the continuing learning needs of nurses, nurse-physician teamwork and compliance with medical regimens. In 1970, Baumgart was the first Canadian to be awarded a Milbank Foundation Fellowship. Under the auspices of the Milbank Foundation she has travelled widely in North and South America viewing innovations in health sciences and professional health education.

In 1973 Baumgart was awarded the 3M Nursing Fellowship by the International Council of Nurses.

Louise Lemieux-Charles has joined the staff of the Registered Nurses Association of Ontario as project co-ordinator of the Association's Nursing Process Project. As overall co-ordinator she will be responsible for liaison with the steering and regional committees, evaluation of the project and preparation of a report outlining the project's activities and results.

Lemieux-Charles recently completed her M.Sc.N. in community mental health at the University of Toronto. She also holds her B.Sc.N. from the University of Ottawa and a diploma in nursing from Ottawa General Hospital.

Edythe Huffman, director of nursing at the Grace Hospital in Calgary, Alta., was named 1977 Nurse of the Year by the Alberta Association of Registered Nurses during the association's celebrations of its 60th anniversary. The award was presented to Huffman by the Hon. Justice Tevie H. Miller in recognition of her contribution to both her community and her profession.

In making the award, the association recognizes Huffman's imaginative direction of the maternity care in which her hospital specializes. An example of this is the arrangement of the post-partum/nursery staff so that the nurse looks after both mothers and babies, a concept that has been well received.

Huffman is involved in community association projects, such as the Anti-Suicide Line in Calgary and is an active member of her professional association.

Mary E. (Sally) Robertson (B.Sc.N., Mt. St. Vincent University, Halifax) has begun a "summer residency" at CNA House to complete the requirement for the program leading to a Master's degree in Health Administration at the Faculty of Management Sciences, University of Ottawa. Her residency at CNA is entitled "An Internal Study of the Effectiveness of the



Organizational and Managerial Effectiveness of CNA." In preparing her preliminary paper on the current status of CNA and its managerial activities, she will seek to identify problem areas and determine future objectives of the organization.

Previously, Robertson has been an instructor in clinical nursing and sciences, a consultant in nursing education and administration for the Hospital Commission of Nova Scotia and a director of inservice educational programs and nursing in Arizona.

Constance A. Swinton (R.N., Royal Alexandra Hospital School of Nursing, Edmonton; B.N., McGill University; M.P.H. University of Michigan) on loan to CNA from the Canadian International Development Agency, has recently completed a six-week feasibility study regarding the possibility of creating an "international unit" within CNA. In the course of her study, she reviewed CNA's present involvement in international projects and has made recommendations for future development in international nursing.

Swinton, who has worked in Indonesia with CARE/MEDICO as a consultant in community health and soon to leave for Nepal to work on a community health development project, believes that it is important for Canadian nurses to be more involved in overseas work. The focus of international health development, she stated, is on the preparation of local people to help themselves in developing services for their own villages and communities. These self-help efforts can be facilitated with Canadian funding and professional guidance especially in the rural areas of the developing world where the need is the greatest.

CNA is already assisting other national nursing associations abroad in improving nursing education and practice in their own countries. An "international unit" Swinton argues would serve to inform CNA members of the needs of nurses in developing



countries and solicit their support and, secondly, would provide the means by which assistance can be directed to nurses abroad. As a coordinating body, the unit would also provide scope for interested nurses across Canada to take part in international health development.

Connie Swinton has been director of education and projects at the national office of the Victorian Order of Nurses; public health consultant with child and adult health services, Health and Welfare Canada and an assistant professor in the population unit, School of Hygiene, University of Toronto.

Calendar

August

International Association for Enterostomal Therapy 1977 Conference to be held at the Town and Country Hotel, San Diego, California, on August 14-17. For information contact: *Melba Connors, Conference Chairman, 124 E. Lewis St., San Diego, CA 92103.*

MEDINFO '77 — Second world conference on medical informatics. A four-day conference to be held in Toronto at the Harbour Castle Hotel on August 8-12, 1977. For information contact: *M.L. Barrett, Medinfo '77 Organizing Committee, 212 King St. West, Suite 214, Toronto, Ontario, M5H 1K5.*

September

Emergency Nurses Association of Ontario Annual Conference to be held September 12-14, 1977 at the Skyline Hotel, Ottawa, Ontario. Contact: *Helen McPhee, Supervisor, Emergency Department., Ottawa Civic Hospital, 1053 Carling Ave., Ottawa, Ontario.*

Fourth Annual Meeting of the Ontario Psychogeriatric Association to be held on Sept. 19-21, 1977. Theme: Bringing Continuity to Care. Contact: *Dr. M. Farquhar, P.O. Box 14, Postal Station "C", Toronto, Ontario, M6J 3M7.*

Initial Assessment and Management of Patients with Acute Illness and Injury. A two-day seminar sponsored by the Emergency Nurses Group, a special interest group of the RNABC. To be held on Sept. 30 - Oct. 1, 1977 at the Four Seasons Hotel, Vancouver, B.C. Contact: *Linda J. Clark, c/o Emergency Nurses Group, Box 86824, North Vancouver, B.C.*

Annual Conference of Northern Ontario Operating Room Nurses to be held September 16-17, 1977 at the Sheraton Caswell Hotel in Sault Ste. Marie, Ontario. For information contact: *Mrs. A.M. McPhee, R.N., General Hospital, Sault Ste. Marie, Ontario.*

Clinical Appraisal Audit, a one-day seminar to be held on Sept. 26, 1977 in the Orange Theatre, Health Sciences Centre, University of Calgary, Calgary, Alberta. Contact: *Jocelyn Lockyer, Administrative Assistant, Faculty of Medical Education, The University of Calgary, 2920 24th Ave. N.W., Calgary, Alberta, T2N IN4.*

October

Sixth Annual General and Scientific Meeting of The Canadian Association on Gerontology to be held October 13-16, 1977 in Montreal at Loews "La Cite" Hotel. Contact: *Blossom T. Wigdor, Ph.D., Director, Psychology Services, Queen Mary Veterans Hospital, 4565 Queen Mary Road, Montreal, Quebec, H3W 1W5.*

28th Annual Meeting of the Ontario Public Health Association to be held on Oct. 18-21, 1977 at the Skyline Hotel in Rexdale, Ont. Contact: *Kae Sutherland, OPHA, 7 Carlis Place, Port Credit, Ontario, L5G 1A8.*

12th Operating Room Nurses Conference to be held by the O.R. Nurses of Nova Scotia on Oct. 18-20, 1977 in Halifax. Contact: *Miss L. Hirtle, R.N., Halifax Infirmary (OR), 1335 Queen St., Halifax, Nova Scotia.*

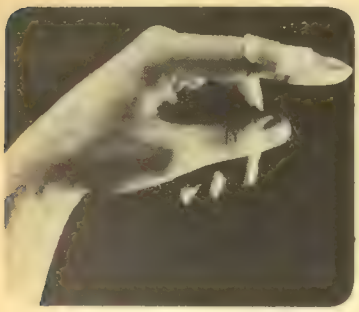
Annual Rehabilitation Nursing Course for Registered Nurses and Registered Psychiatric Nurses to be held Oct. 17- Nov. 4, 1977 at Wascana Hospital, Regina, Sask. For information, write: *Mrs. Audrey Balon, Co-ordinator of 1977 Rehabilitation Nursing Course, Wascana Hospital, 23rd Avenue and Avenue 'G', Regina, Saskatchewan. S4S 0A3.*

Did you know ...RAH

The class of '73 of the Royal Alexandra Hospital, Edmonton is having its five year reunion in the summer of '78. All RAH '73 graduates are asked to send in a resume, name and address for a new annual class newsletter along with a self-addressed stamped envelope to: Roseanna Burchert, 13112-42nd Street, Edmonton, Alta., T5A 2V5. Include any suggestions for five year reunion. Please submit by August 31.

Information is supplied by the manufacturer; publication of this information does not constitute endorsement.

What's New



Stack Finger Splint

A new finger splint has been introduced by Link America, Inc. Known as the Stack Finger Splint, it is designed to support the distal joint of the finger in extension, while permitting unrestricted movement of the proximal interphalangeal joint.

The splint is fixed to the middle phalanx with a small strip of adhesive tape, thus elevating the distal joint to its extended position.

The Stack Finger Splint is made of flesh-colored plastic, which is perforated for ventilation and maximum comfort. Available in six different sizes.

For further information contact: Link America, Inc., 10 Great Meadow Lane, E. Hanover, NJ 07936.

Two Organizers

An electronic diary is an aid to senior executives and professionals. About the size of a quality pen-pencil desk set with modern sculpture styling, it is entirely electronic and battery-operated (standard batteries last one year), clock and special reminder sheets are built in.

The electronic signal is activated by bridging the 15-minute intervals with lead pencil provided. A buzzer rings intermittently for 2 minutes ahead of reminder, cancelled by push button.

Plan-A-Year is designed around the 28-day month, showing weekends separately. Available in 3 sizes. Desk top (16" x 12"), desk or wall (24" x 16") or wall (36" x 24"). The wall size has a specially treated surface for information that must be changed.

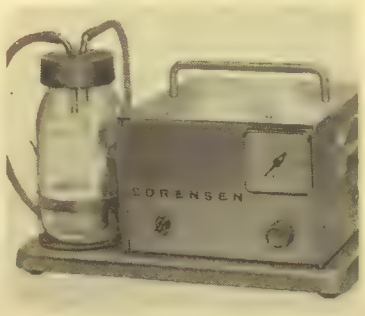
Further details from: Nan-Neil Limited, Box 100, Coe Hill, Ontario, K0L 1P0.

Portable Aspirator

Vernitron introduces a portable aspirator (Model No. 1600) for quiet, continuous usage in nursing homes, hospitals, dentists' and physicians' offices — or anywhere that a compact, portable aspirator with strong suction and positive, fail-safe regulation may be needed.

The aspirator includes a float-type cut-off valve contained in a secondary reservoir which switches the unit off, should the collection bottle be permitted to overfill. Thus the pump and motor are protected against damage from fluid contamination.

The 0-20 inch suction capability of the Model No. 1600 is displayed on an extra large, 2 1/2" vacuum gauge dial with a 270° scale calibrated in inches of pressure. The compactness of the aspirator is enhanced by an aluminum case which completely encases the motor and pump assembly. The case is equipped with an easily accessible, balanced carrying handle. A cord wrap is also provided for easy storage of the three-conductor hospital-grade cord and plug.



The Model No. 1600 Sorensen aspirator is provided with a 64 oz. glass collection bottle graduated in cubic centimeters, and equipped with a snap-fit, molded rubber bottle cap and fittings. The bottle is secured in a stainless steel bottle holder. The overall size of the unit is 14"x 8 1/2" x 10 1/2" and the net weight is only 15 lbs. The Vernitron Model No. 610 mobile stand is available for use with this aspirator.

For information contact: Vernitron Medical Products, Inc., Sales Department, 5 Empire Blvd., Carlstadt, New Jersey 07072.

New "Akro-Sil" Foley Catheter

An irritation-free service life two to three times longer than that of conventional latex catheters is claimed for a new Foley catheter announced by Akron Catheter, Inc. Termed a "new generation" of catheter, it carries the trade name "Akro-Sil."

Made from a homogeneous mixture of latex and silicone the new catheter combines the best features of each material.

The low porosity of the Akro-Sil catheter's surface minimizes the build-up of calculus deposits, which are the major cause of irritation in indwelling catheters.

Because the permeability of the new material is much lower than that of silicone and equal to that of latex, the Akro-Sil catheter's balloon will remain securely inflated for as long as the catheter is in use. In addition, the material's elasticity provides complete balloon recovery on deflation so that removal trauma is avoided.

For information contact: Akron Catheter, Inc., Akron, Ohio 44313.

Surgical Grounding Pad System

Medical Plastics Inc. has an Electro-Surgical Grounding Pad System that includes two sizes of flat disposable grounding plates for grounding the routine electro-surgical patient, plus a new small pregelled disposable foam self-adhering grounding pad that contours to the patient's body and is ideal for the difficult to ground patient.

One patient cable is used with both grounding plates and the grounding pad. It is clear, with visible wires to allow inspection of the connection prior to, and during, each procedure.

Cable connector provides a positive contact and is adaptable to all electro-surgical units.

The M.P.I. Surgical Grounding Plate System comes in different styles and sizes and provides safety, convenience, and economy for the operating room.

For information write: Medical Plastics, Inc., 15318 Minnetonka Industrial Road, Minnetonka, Minn. 55343. U.S.A.

Blood Pressure Unit

Manoscope Inc. is offering a new blood pressure unit designed for both professional and home use. The unique self-locking circular cuff can be easily applied to your arm without assistance.



The unit also features a recording manometer. Two hands automatically follow the pressure dial and are simply released by a push button. The systolic pointer locks in on the high reading and the diastolic pointer locks in on the low reading by pushing a control button. This eliminates the memory factor and allows the readings to remain even after the cuff has been deflated.

Another feature allows two stethoscopes to be connected simultaneously to aid in teaching people to read their own blood pressure accurately. The complete unit also contains a record-keeping diary and an illustrated instruction booklet.

Approximate price: $49.95. For further information, write: Manoscope, P.O. Drawer 1956, Clearwater, Florida 33517.

Push-Button Sphygmomanometer

Propper Manufacturing Company has introduced a sphygmomanometer with one-finger push-button control for easy deflation and a "blue-faced" dial with white numbers, affording clear visibility to the practitioner only.

The "Push-Button" ™ Sphygmomanometer represents a completely new concept in measuring a patient's blood pressure in that the push-button valve eliminates the old-fashioned knob-turning device, offering increased accessibility, speed and control of air release. Both the air release and inflation bulb mechanisms are connected to form a single, sturdy, convenient unit. The new connection removes the need to hang the manometer on the cuff. Also, support is built into the bulb for quick inflation.

For information write: Propper Manufacturing Company Inc., Diagnostic Instrument Division, 36-04 Skillman Avenue, Long Island City, New York 11101.

Pediatric O.R. Pad

MI Systems, Inc. has now made available a Pediatric O.R. Pad consisting of four small electrodes mounted precisely on a foam pad. It is applied to the infant's back to provide accurate monitoring of the infant's heart during open heart or chest surgery. It is also excellent for use during special applications where reduced size is desired on adult patients.

MI's pediatric O.R. Pad is pre-gelled with a low chloride gel and gives high electrical performance. It is easily applied after peeling off the protective liner. (It is also available non-gelled, if desired.)

MI's pediatric O.R. Pad comes with its connecting wire as an integral part of the unit and with either male or female adapter cable. It is also available with a built-in cable that will adapt to the traditional five-lead cable and another to fit into other existing systems.

MI's pediatric O.R. Pad is packed in a moisture-proof bag with freshness guaranteed for one year.

For further information write: MI Systems, Inc., 782 Burr Oak Drive, Westmont, IL 60559.

Visual Scheduling System

A visual staff scheduling system, the Beanstalk, consists of wall-mounted modular and boards and inch square colored cardboard tabs clipped into plastic holders. The tabs can be written on and dropped firmly into place anywhere in the grid pattern.

The system provides a complete overview of the nursing staff complex at a glance, yet the system itself is simple and easy to maintain.

Details of this system and many similar applications are available from: Kentron Services, 50 Firwood Crescent, Islington, Ontario M9B 2W2.



New N-Labstix for Detection of Urinary Tract Infection

Ames Company has extended their range of dip and read urine chemistry tests, with the addition of NITRITE to their LABSTIX reagent strip. Nitrite is specifically for the detection of urinary tract infection. Research has shown that an alarming incidence of such infection is detected among asymptomatic patients.

Extensive testing has shown that N-LABSTIX can detect 92% of urinary tract infections where urine was incubated in the bladder four hours or longer. The addition of the Ames nitrite test brings to six the number of tests available on N-LABSTIX, the others being pH, Protein, Blood, Glucose, Ketones.

For information contact: Ames Company, Division of Miles Laboratories Ltd., 77 Belfield Road, Rexdale, Ontario.



Audiovisual



A scene from "Crisis Intervention."

■ Mental Health

Crisis Intervention

This is a set of two filmstrips which has been introduced by Nurseco to illustrate the concept of psychological crisis and to teach step-by-step techniques for nursing intervention. The films are designed:

- to enable nurses to differentiate between adaptive response to a loss and a state of crisis
- to describe behaviors indicative of a person in a hazardous or crisis state
- to specify nursing intervention based on assessment of the balancing factors
- to apply the filmstrip content to patients in a clinical setting.

Part one of "Crisis Intervention" explains the dynamics of crisis theory; the hazard, losses, precipitating event, assessment and minimum intervention goals. Part two demonstrates intervention planning and evaluation.

The complete set of filmstrips and materials is available for $125. Additional information may be obtained from Nurseco, P.O. Box 145, Pacific Palisades, California 90272.

The Adolescent Iliad

A twenty-five minute color documentary concerning the behavior-modification program at a state hospital. The film shows young people under treatment for serious emotional problems including drug abuse, aggression, stealing, running away from home, withdrawing and dropping-out of school. The dynamics of the behavior-modification program lead to acceptance of responsibility through scenes of confrontation and awakened self-awareness. Produced by Lauren Productions the film can be purchased for $315 or rented at $35. For information contact City Films Ltd., 376 Wellington Street West, Toronto, Ontario, M5V 1E3.

Adolescence and Learning Disabilities

Six nationally recognized innovators define the tasks of adolescence and offer specific suggestions and techniques for helping the learning-disabled student acquire the skills necessary for survival after he/she leaves school. A 25-minute color film by Lauren Productions that is available for a $35 rental fee or a $380 purchase price. For information contact City Films Ltd., 376 Wellington St. West, Toronto, Ontario, M5V IE3.

■ Nutrition

Eat, Drink and Be Wary

This 21-minute color film presents a critical examination of our eating habits. The topics discussed include nutritional losses in food processing, food additives and the role of the food manufacturer in changing our diets. The film was produced in 1975 and is available at a $295 purchase price or a $25 rental fee from Gordon Watts Films, 865 Sheppard Avenue West, Downsview, Ontario, M3H 2T4.

For Tomorrow We Shall Diet

A young woman sets out to lose 20 pounds. Through the course of her diet both she and the viewer discover the need to change our eating habits, the dangers of fad diets, the relationship between calories and energy output and the importance of proper nutrition and exercise. The film is a 24-minute color presentation available from Gordon Watts Films, 865 Sheppard Avenue West, Downsview, Ontario, M3H 2T4; purchase price $335, rental fee $25.

■ Obesity

Human Dynamics of Weight Control

Doctor Jimmie Holland outlines the sources and types of obesity, and then discusses the relationship of both psychological states and socioeconomic status to obesity. This 26-minute slide/tape presentation is available for $17.70 from Communications in Learning, 2929 Main Street, Buffalo, New York.

Behavior Modification Component in the Treatment of Obesity

This program reviews the effects of psychological aspects in causing and treating the problems of obesity. The patient's moods, anxieties and activity levels are considered with behavior modification used as a treatment modality. This is a 37-minute slide/tape presentation that is available for $26.40 from Communication in Learning, 2929 Main Street, Buffalo, New York.

■ Family Planning

Birth Control: The Choices

A 25-minute color film presenting the uses, limitations and side effects of the usual methods of birth control, as well as tubal ligation, vasectomy and abortion. A physician, a birth control counselor, and several young people relate their experiences and explore the choices available to them. The film is available from Gordon Watts Films, 865 Sheppard Avenue West, Downsview, Ontario, M3H 2T4. Purchase price $350, rental fee $25.

Vasectomy

Animation describes the male reproductive system and vasectomy surgery. Interviews with men and their wives tell of reasons for having a vasectomy and of their feelings, fears and satisfactions. This 17-minute color film is available from Gordon Watts Films, 865 Sheppard Avenue West, Downsview, Ontario, M3H 2T4; purchase price $240, rental fee $21.

■ Pediatrics

Infant Failure to Thrive

Dr. Harry M. Beirne discusses the 'failure to thrive' syndrome in infants and young children. He emphasizes the so-called "maternal deprivation" group. This is a 25-minute slide/tape presentation that is available for $11.40 from Communication in Learning, 2929 Main Street, Buffalo, New York.

■ Medicine

Team Up to Control Infection

A 15-min. color film shows how all levels of hospital personnel can help to control infection. Available in 16 mm from the Librarian, Canadian Hospital Association, 25 Imperial St., Toronto, Ontario M5P 1C1.

■ Rehabilitation

The Curb Between Us

A 15 1/2-min. color film documenting a young man's struggle to rebuild his life after a disabling accident and nine months in hospital. It explores such questions as: How does it feel to become disabled? What are the prejudices directed against anyone who is different? Can the problems and needs of the disabled be solved? How can the able help the disabled? Available from the Canadian Film Institute, 303 Richmond Rd., Ottawa, Ontario, K1Z 6X3.

Vocational Rehabilitation in a Community Hospital

This 27-minute, color film shows a hospital-based program of vocational rehabilitation for victims of arthritis and other chronic ailments. Step-by-step it follows actual patients and the program's professional staff through the full rehabilitation process: job counseling, aptitude testing, evaluation and instruction, and placement service. To request this film contact the Canadian Film Institute, 303 Richmond Road, Ottawa, Ontario, K1Z 6X3.

Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Research

- **Public Health Nursing**

An Analysis of the Application of the Concept of Family-Centered Care in Public Health Nursing Visits. Nursing research conducted at the University of Toronto, Toronto, Ont. by *Rosella Cunningham. (B.Sc.N., M.P.H.).*



This exploratory study was designed to determine if family-centered care was a reality or a cliché in public health nursing services offered by official health agencies in 1976.

In this project the criteria for giving family-centered care included evidence that the nurse:
1. Interprets public health nursing as family-centered,
2. Is concerned about all members of the family,
3. Has talked with all the family members to assess and identify problems or potential problems related to health promotion and early case-finding,
4. Is aware of the effect of the problem on the family,
5. Is aware of the effect of the family on the problem.

Data were collected by observing one home visit made by each of 20 randomly selected public health nurses. These visits were to families who had received at least two previous visits in the last six months and spoke and understood English. Following the visits, the nurse's record was reviewed and the nurse was interviewed using an interview schedule. Instruments were developed to record these data.

The data were analyzed according to the five criteria, and factors that influence the implementation of family-centered care were listed.

The observations of home visits made in this study were highly encouraging: 15% of the nurses met all stated criteria and the majority rated very high (40% met at least 4 criteria and 55% met 3 or more criteria). It should be emphasized that while 2 nurses met none of the criteria for family-centered care, that does not mean they were failing to give good individually-centered care. The fact that 80% of the nurses observed were aware of and concerned with the interweaving of problems, personalities and environment showed they had an excellent base for providing family-centered care.

Recommendations for improving family-centered care are directed to nurses, agencies, educators, and researchers.

- **Continuity of Care**

The Effects of Continuity in Nurse-Patient Assignment among a Selected Group of Preoperative Aortocoronary Bypass Patients. Toronto, Ont., 1976. Thesis (M.Sc.N.), University of Toronto by *Julia M. Pelletier Rosa.*

The purpose of the study was to investigate systematically the effects of two different methods of preoperative nurse-patient assignment on selected preoperative and postoperative indicators in aortocoronary bypass patients.

A convenience sample of 24 patients, admitted to a large metropolitan hospital for their first elective aortocoronary bypass surgery, was chosen. The investigator visited each patient in his home preoperatively to obtain formal consent and administer a test of state anxiety: Zuckerman's Affect Adjective Check List (AACL) — Today Form. Upon admission to the hospital, patients were randomly assigned to one of two groups as in accordance with a randomized block design:
1) DN-PAC group where patients experienced daily nurse-patient assignment changes on each shift, each day preoperatively; and
2) CN-PA group where patients experienced continuous nurse-patient assignment on each shift, each day preoperatively. The investigator again administered the AACL the evening before surgery. Data were also collected in relation to postoperative indices of analgesia requirement in the first 48 hours postoperatively, time spent in the Intensive Care Unit, and assessment of patient's ability to deep breathe, cough and move extremities. A postoperative interview was conducted with the patient to survey the patient's ability to recall having "his nurse" preoperatively, the importance to him of having "his



nurse," and the extent to which he related to the nurse and/or others as sources of support. Data pertaining to the patient's perceptions of his preoperative nursing care were also collected.

Findings demonstrated that patients' scores on the AACL did not differ significantly between the two groups either at home or in hospital. It was found that foreign born, unmarried and more highly educated patients scored higher on the AACL than did their counterparts.

There was no statistically significant difference between the two groups in patients' time spent in ICU, analgesia requirement or in the patient's ability to deep breathe, cough and move extremities.

Eight of the 12 CN-PA patients could remember having "their nurse" preoperatively; 11 of the 12 DN-PAC patients could not. If given the option, 18 of the 24 patients stated they would like to have had the same nurse assigned to them for a period of time preoperatively.

Only three of the 24 patients reported discussing worries with their nurses preoperatively. Twenty preoperative patients interacted with postoperative patients. The majority stated that they found such interaction to be supportive.

There was no difference between the groups in patients' overall level of satisfaction with their preoperative nursing care. However, in choosing what they liked best about their preoperative nursing care, patients in the CN-PA group chose with greater frequency than the DN-PAC group, items which described the nurse's supportive role. Conversely, DN-PAC patients chose items which described the nurse's technical role with greater frequency than the CN-PA group.

Continued research of continuity of care is recommended. Planned utilization of other surgical patients as sources of support requires further examination. The provision of a routine home visit by a staff nurse to reduce the preoperative aortocoronary bypass patient's and his family's anxiety is recommended. Research should be conducted to identify groups of patients who may exhibit a predisposition to greater anxiety.

Did you know ....

In California, Governor Edmund Brown Junior recently signed into law a "right to die" measure. The new law allows a person to prepare in advance a "living will," which legally permits the removal of life-support equipment, such as respirators, if death is "imminent." The law protects health personnel against legal action and does not permit insurance companies to label such deaths as suicides.

Internationally, Sweden legalized passive euthanasia in 1964. In Italy, euthanasia is a crime only if a patient is under 18, mentally retarded or "menaced under the effect of fear." Other European countries have similar legislation. *(The American Nurse, Dec. 15/76)*

Books

The Nursing Process: A Scientific Approach to Nursing Care by Ann Marriner. 241 pages. St. Louis, The C.V. Mosby Company, 1975. *Approximate price $7.10. Reviewed by Irmajean Bajnok, Assistant Professor, Faculty of Nursing, The University of Western Ontario, London, Ontario.*

This book represents an attempt to compile theoretical concepts related to the nursing process. The components of the nursing process identified and discussed are assessment, planning, implementation, and evaluation. Each chapter represents a component of the nursing process, and contains Marriner's writings plus a number of selected readings which illustrate and/or expand the component. An extensive annotated bibliography is also included with each chapter. All in all, the book provides an excellent package of readings and references pertinent to the nursing process.

The introductory chapter provides a concise outline of what is to follow. The author, however, does not define nursing, nor does she identify the importance of a conceptual framework of practice in guiding the nursing process. One might assume that this work represents a conceptual basis for practice. Because Marriner provides no rationale for her beliefs her conceptual basis is not clearly identified. This omission makes it difficult to see any unity in Marriner's discussion of the nursing process.

The chapter on assessment is complete, with a myriad of nursing techniques and tools for collecting descriptive data about the client. Marriner states that the assessment phase of the nursing process ends with the nursing diagnosis. Her definition of this concept is unclear, and it is addressed as something apart from assessment. Because assessment begins with screening, which assumes categorization of raw data, it is mandatory that a diagnostic framework be used throughout this phase. The carefully selected readings related to assessment and diagnosis strengthen this chapter. Chapter three stresses priority setting, written plans and nursing conferences in the planning phase of the nursing process. Again the readings at the end of the chapter are both interesting and appropriate. With the recent emphasis on the importance of identifying patient outcomes, perhaps more space could have been allotted to this topic.

In the chapter describing the implementation component of the nursing process. Marriner discusses the concept of teaching/learning almost to the exclusion of any other nursing strategy. Surely nursing strategies are not limited to teaching and communication. The selected readings at the end of this chapter are extensive and offer a variety of case studies describing nursing problems and strategies.

In the final chapter on evaluation, Marriner briefly discusses the issue of assessing patient progress then proceeds to address nursing audit, systems analysis and performance evaluation. Evaluation that is intimately part of the nursing process is the means whereby the nurse and client measure actual client outcomes against predetermined outcomes. The broader concept of evaluation includes provider outcome measures, client outcome measures, and total program effectiveness. It is most important that we clearly distinguish provider outcome, client outcome and program evaluation. Also important is that nurses not confuse assessment, (that is, the precursor to decision) and evaluation, that determines the effectiveness of intervention. Since Marriner focused on provider-oriented performance measures, the notion of measuring effectiveness was lost or at least confused. The selected readings in this chapter relate to program and provider performance evaluation.

In summary, Marriner has succeeded in presenting a much needed compilation of information related to the nursing process. This book would be an excellent resource for both faculty and students involved in teaching and learning the nursing process.

Teaching Children with Developmental Problems — A Family Care Approach, Second Edition. by Kathryn E. Barnard and Marcene L. Erickson. 182 pages. St. Louis, The C.V. Mosby Company, 1976. *Approximate price $6.25. Reviewed by Karin von Schilling, Associate Professor, School of Nursing, McMaster University, Hamilton, Ontario.*

This is the second edition of a book formerly titled *Teaching the Mentally Retarded Child — A Family Care Approach.* As the new title indicates, the focus has shifted from a specific group of handicapped children — the mentally retarded to a wider scope, which more inclusively refers to "children with developmental disabilities" of any nature.

Apart from some up-dating in the chapter on Nursing Responsibilities, including a new chapter on Group Discussions with Parents, and an expanded index section, the new edition presents few changes in organization and content.

The book is organized into four major sections. The first two sections deal with identifying overall nursing responsibilities regarding the disabled child and his family. Emphasis is on recognition of problems, with considerations for developmental and learning principles within the family context. The third and fourth sections focus more specifically on the application of principles by providing methods of assessment and observation and practical suggestions for assisting the child in his development and the learning of self-care skills.

The authors emphasize that the helping professions, with their knowledge and support, can play a decisive role in assisting parents to assess and meet the developmental needs of their disabled child, particularly during the critical periods of infancy and the preschool years. This offers support for the trend of family care for disabled children.

The section on family considerations provides essential understanding; here the authors recognize that parents cannot assume an effective teaching role with their child unless the crisis of having a disabled child has been resolved with adaptations which mobilize energies for a positive and realistic approach to the child's development. The new chapter on Group Discussions with Parents explores benefits and offers practical suggestions for the employment of this method in assisting parents to deal with their own as well as the child's problems.

The organization of contents offers access to any area of interest. Each section and each chapter could be utilized independently for practical purposes. Throughout the book, summary charts provide organized and detailed information. Both the professional worker and/or parents will find this book a practical and valuable source of assistance when dealing with a disabled child.

One could question the wisdom of changing the title for the second edition. The content, its focus on primary developmental skills with associated assessment tools and detailed teaching-learning strategies, is primarily designed for application in work with retarded children. Will the omittance of a clear reference to "The Mentally Retarded" in the title, reduce the recognition and access of this book to its primary field of usefulnes — teaching the mentally retarded child?

Introduction to Physiological and Pathological Chemistry by L. Earle Arnow, Ninth Edition, 491 pages, Saint Louis, The C.V. Mosby Company. *Approximate price $12.55 Reviewed by David Khokhar, Halifax Infirmary School of Nursing, Halifax, Nova Scotia.*

Scientifically, we are passing through an exciting era. *Physiological and Pathological Chemistry* seems to achieve its objectives from the learning perspective.

The problems of ecology are arising from pollution of the environment by wastes of all kinds. Detergents, insecticides, hydrocarbons, and radioactive materials — these wastes make it imperative that modern students have a background in the basic sciences. It is necessary to be grounded in physical and chemical sciences before anything more than a superficial descriptive acquaintance with living organisms can be achieved. The student will therefore profit most from his course in pathology, if he has some knowledge of biological chemistry preferably including organic chemistry.

The subject matter is adequately treated, and one is particularly impressed with the fact that this

text contains many areas that are often omitted.

The main points in each chapter are clearly and concisely explained; this facilitates both learning and teaching. The book includes a discussion of the latest basic chemical, biochemical and microbiological principles. The illustrations are excellent, but at times too complicated. It seems to me that the text is too advanced for use in diploma nursing or paramedical courses but would be of considerable use to university students.

The material is sufficient and presented in an interesting way, generating student interest and motivation.

Childbearing: A Nursing Perspective by Ann L. Clark and Dyanne D. Alfonso. 945 pages. Philadelphia, F.A. Davis Company, 1976.
Approximate price $23.70
Reviewed by F.L. (Nan) Sparks, Associate Professor, University of Calgary, Faculty of Nursing, Calgary, Alberta.

Clark and Alfonso have utilized a conceptual frame of reference in their delightful new testbook *Childbearing: A Nursing Perspective.* As the authors state in the preface, a conceptual approach "is one way to organize knowledge and to apply it appropriately for nursing intervention." The text is successful in its goal. Not only is basic maternity knowledge presented, but there is also a wealth of information in the book regarding the role of nursing.

The text is divided into several units, with contributions to many units from experts in other fields. Unit Two outlines some psychosocial concepts such as Joy, Touch and Sensuality, Frustration and Conflict, Anxiety, Loss and Crisis, concepts absent from or limited in other maternity nursing texts. The authors go on to further integrate and apply these concepts in later units on pregnancy, labor, delivery, and the post-partum period.

Unit Three focuses on cultural perspectives in childbearing and includes a cultural assessment framework which will aid in understanding various family responses during pregnancy and delivery.

Although emphasis is given to this new psychosocial material, basic physiological content has not been neglected. Several guides are included in the text for physiological assessment of nutritional status, prenatal care, maternal risk factors and examination of the neonate.

Unit Ten deals with Crisis During Childbearing and includes chapters on adolescence, abortion, prematurity, death and abnormalities. Unit Eleven presents for discussion some legal, moral, and ethical issues such as cultural warping of childbirth, population problems and child abuse. These last two units are an interesting and necessary addition to a contemporary basic maternity textbook.

The authors state that the book was written for students learning the profession of nursing but that it might also be a useful review of maternal-neonatal nursing for nurses in clinical practice. In either case, this is an excellent, easily read, current and well-researched book.

Total Parenteral Nutrition, edited by Josef E. Fischer, M.D., 454 pages, Little, Brown and Co., Boston, 1976.
Approximate price $25.00
Reviewed by Therese Koazk, R.N., Paediatric Parenteral Nutrition Nurse, Vancouver General Hospital, Vancouver, British Columbia.

"Total Parenteral Nutrition has been a reality in this country for less than ten years, but already thousands of patients are in its debt, many for their lives." The thirty contributing authors of this book, all leading experts in their fields, examine this important contribution to the treatment of our patients and discuss general principles, clinical applications, and supplemental techniques to central parenteral nutrition.

In the first part of the book, the authors discuss the particular needs of various patients with respect to their underlying problems, solutions available with their varying constituents, as well as some of the complications associated with central venous parenteral nutrition. Techniques associated with prevention of such complications are reviewed. However the frequent problems with fluid and electrolytes often encountered in parenteral nutrition are not stressed sufficiently.

Phillips and Colley, hyperalimentation nurses at Massachusetts General Hospital, have discussed in detail specific aspects related to the nursing care of the patient on parenteral nutrition stressing the importance of preparing the patient for the therapy and the precision and accuracy involved in insertion and care of this vital lifeline. Education of all personnel involved is demonstrated as being extremely important — particularly impressive is a workshop day in which the theoretical background of hyperalimentation therapy and its associated nursing care is presented and discussed. The work conference is available to selected applicants (nurses) within the hospital as well as to outside visitors. Several practical suggestions for organizing a Parenteral Nutrition Unit are discussed.

The second part of this book deals with specific aspects of management in the treatment of patients with specific systemic diseases. Patients in renal failure, severe cardiac disease, inflammatory bowel disease, intestinal fistulae, hepatic failure, burns, and pediatric patients may each develop specific problems related to their condition and require close and careful management with respect to the administration of intravenous feeding. Advances

(Continued on p. 48)

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already made such as ambulatory parenteral nutrition are exciting and help to convince us that this lifesaving technique is truly a milestone in medicine.

The final part of this book includes techniques supplemental to central parenteral nutrition. It is disappointing to find that the chapter on peripheral administration of isotonic lipids and amino acid preparations is included in this section, rather than as an alternative technique to central venous feeding. The importance of including fat in the diet is stressed. Elemental diets or more commonly called "space diets" are fast becoming an accepted and popular supplement to central parenteral nutrition, as we struggle to feed our patients via the normal route of ingestion. Complications of elemental diets make us aware of the need for more research in this area.

I do recommend this book as an excellent source of reference in this field. The illustrations and in depth presentations are designed to teach those seeking more understanding of parenteral nutrition.

Bedside Diagnostic Examination 3rd edition. by Elmer E. DeGowin and Richard L. DeGowin. 952 pages. New York, MacMillan Publishing Company, Inc., 1976. Canadian Agent: Collier MacMillan Canada Limited, Toronto.
Approximate price $12.95
Reviewed by Rene A. Day, Assistant Professor, Faculty of Nursing, University of Alberta, Edmonton, Alberta.

As the title suggests, this text is designed to prepare the medical clinician to use history taking, physical examination and lab tests to arrive at a diagnosis. However, the book can certainly be used by nurses involved in physical assessment.

The first three chapters provide a thorough introduction to the physical examination and stress the importance of obtaining a good history. The four basic skills of inspection, palpation, percussion and auscultation are very well presented.

Two types of examinations are described: the screening examination of clients presumed to be well and having no symptoms, and the diagnostic examination to find a disease that is causing discomfort or dysfunction. Examples are given illustrating the order for performing physical examinations in different settings, i.e., beginning with the client sitting as in a clinic setting versus beginning with the client lying in bed as in a hospital setting. These two examples are of real benefit to nurses in helping to organize all the components of the examination into an integrated whole that will be most effective and least tiring for the client.

The remainder of the book describes each body system, reviewing the anatomy and physiology, pertinent information to be collected in the history, and the specific techniques of the examination. An important feature of the book is the inclusion of sixty key symptoms or common complaints and a list of possible causes of each. Small hand drawn diagrams throughout help to clarify the written material. The final chapter is an alphabetical summary of common disease conditions with definitions, signs and symptoms, and lab results.

This book would not be suitable as the first or only reference for nurses learning physical assessment; it is too detailed and complex. A good knowledge of medical terms and/or a medical dictionary is required. Basic understanding of anatomy and physiology and the related sciences is assumed by the authors. It is not a book to be studied from cover to cover. Rather, it provides an excellent reference for information about assessment of specific body systems, disease conditions and key symptoms. Because the focus is diagnosis, the book would be a valuable resource to aid any nurse who is in a position to make decisions about the need to refer clients to physicians.

Right and Reason: Ethics in Theory and Practice 6th ed. by Austin Fagothey, 484 pages, The C.V. Mosby Company, St. Louis 1976. *Approximate price $13.15*
Reviewed by Ina Watson, Associate Professor of Nursing, College of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan.

This book is the sixth edition of *Right and Reason* written by Father Fagothey. It was written with the young college student foremost in mind. The purpose is to present major philosophical theories to enable the individual to establish, or to be able to defend, positions on ethical and moral questions.

The first half of the book deals with major topics such as ethics, responsibility, pleasure, intuition, reason. The emphasis in the second half is on the dignity of the human person — such subjects as government, education, health, and war and peace are discussed.

There are thirty-seven units in the book. Each unit follows the same pattern. The problem is stated; arguments pro and con are presented; a summary, and questions for discussion are provided. The units are written in a logical manner and in ordinary language. The summaries are of particular interest as it is here and in the conclusions that the convictions of the author come through. These convictions are stated clearly and concisely, and the reader will be challenged to think in a logical manner about individual ethical and moral values.

Several of the units are of particular interest to the profession of nursing. The unit on Health discusses the problem of man's stewardship over himself. Questions discussed are:
— When may a man risk his life?
— How much care must be given to health?
— Are mutilation and sterilization justified?

It would be helpful if the units on Society-Family and Sex were read together. In these units many questions are discussed: why men live in society and what society is; marriage as a natural or conventional institution; and the place of love and sex in marriage.

Although the audience for this book is the young adult, it is timely and interesting reading for all age groups. It is not a book that will be read at one or two sittings. It is a book to be taken in small bites, digested then resumed.

Clinical Anatomy and Physiology for Allied Health Sciences by Paul D. Anderson, Toronto, W.B. Saunders Co., 1976.
Approximate price: $11.85
Reviewed by Jean W. Spalding, Chairman, Nursing Program, Toronto East General Campus, Centennial College. Scarborough, Ontario.

The positive features of this textbook for students in allied health sciences are numerous. It is written in a style that is readily comprehended, at a level for beginning students in this field. When additional information is available on any subject, the source is clearly identified. The diagrams and tables are excellent. Some information is included in the clinical implications of the disease process, which is usually an area of considerable interest for students and can be utilized as a positive teaching resource. The outlines at the conclusion of each chapter provide a good source for review, and the questions provide assistance for self-directed learning. The glossary, prefixes, and suffixes are also valuable aids to assist the student to comprehend this subject.

Each chapter includes significant information. Chapter I on the Human Organism presents very complex information that is written with clarity, and can be readily understood by beginning students. Chapter II on Radiologic Health is the introduction of current information, a valuable addition in this text. Information on Fluids, Electrolytes and Acid-Base Balance is placed in each chapter in the appropriate physiological context. It would add to the value of this text to have a chapter devoted to this information because of the difficulty many students encounter in understanding this material and its significance in clinical experience.

If this textbook is to be used as a textbook for nursing students in a diploma nursing program, there are some omissions and areas that need an increased amount of information to provide the student with the necessary background for decision-making and clinical experience.

Some of the areas that require an increase in depth are:

- In the Voluntary Nervous System the accurate identification of the areas of decussation of the major ascending and descending tracts of the spinal cord should be included.
- The significant cranial nerves should include the origin, the pathway, the termination and the function.
- In the clinical manifestations of the Respiratory System, it would seem necessary in today's society to include significant data on cigarette smoking in relationship to health and disease.
- Chapter 18 on Digestion and the Alimentary Tract would benefit from increased information on the teeth, the duct system of the biliary apparatus and the physiology of the liver.
- Chapter 20. The female reproductive system is in insufficient detail to provide a thorough background of normal anatomy and physiology for gynecological and obstetrical nursing.

These comments are not meant to indicate a strongly negative impression of this textbook. I feel that students should use more than one text for information, and schools have libraries for such a purpose.

It was a good experience for me to read this text; I feel it has good potential for use an a text in the health sciences field.

Library Update

Publications recently received in the Canadian Nurses Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

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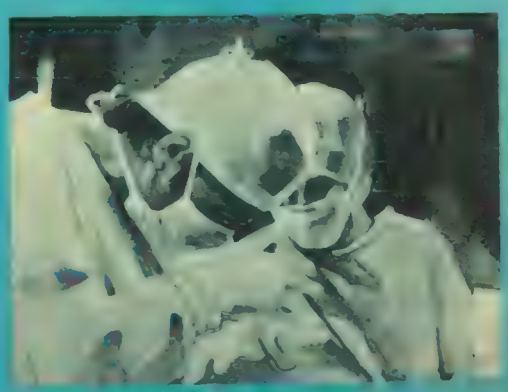
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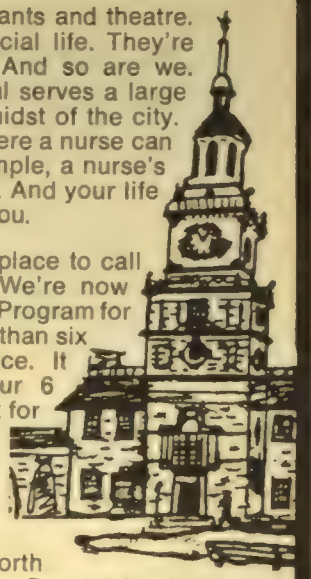
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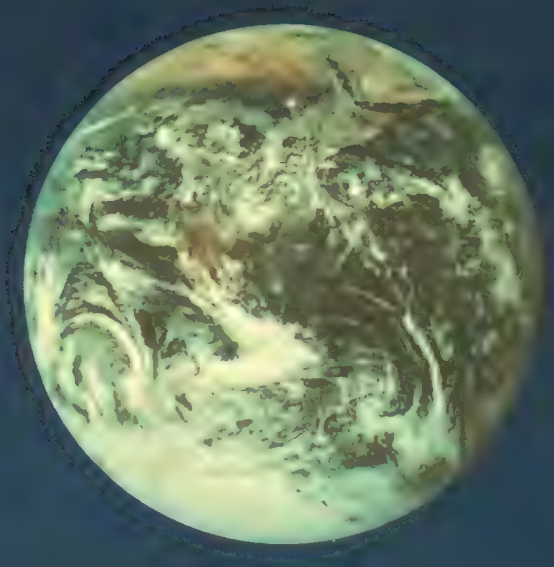
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the canadian nurse

August, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Cover photo: When a group of nurses from Tokyo Women's College Medical Hospital wanted to say "welcome to Japan" to their counterparts from around the world attending the 16th Quadrennial ICN Congress, they chose a program of traditional music performed on instruments such as the koto — the 13-stringed Japanese zither. Dressed in the traditional Japanese kimono, some of the performers are pictured during a reception hosted by the Japanese Nurses Association. (Photo courtesy International Council of Nurses).

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective

With apologies to Wolfgang von Goethe and to Hans Schmitz... Our family being inveterate readers — the kind who for lack of anything else, are sometimes reduced to reading the small print on bread wrappers — it was not really surprising to find myself poring over a garden catalogue at three o'clock on a recent night that proved too warm for sleeping. What was surprising or at least thought-provoking were some of the comments that the author, a landscape artist for 20 years in this country, had to make about the relationship between successful gardening and character development.

"Gardening," as Hans Schmitz sees it, is "a great teacher, not only in skills and knowledge but more so in virtues. A garden reveals the character of its owner. Without sincerity, a searching mind and devotion, one will not be able to develop his garden to maturity. Maturity ... an attainment that seems to have lost its value in these days of over-emphasis on staying young. Gardening teaches patience, finding of truth, refining of taste and, in the long run, influences the character of nations."

On reflection, it seems to me that a strong case could be made for the existence of a close parallel between tending plants and caring for people. Perhaps "gardenculture" and health care have more in common than might, at first, seem likely. And perhaps health professionals like nurses have something to learn from Hans' words of advice to would-be horticulturists. For example, reading on, we find:

on knowledge — "it is wise to inform yourself diligently to avoid disappointment."

on patience and timing — "Don't uncover too early any rose. Wait till lilacs bloom or birches sprout."

on solicitude — "Your plants will very quickly reward you for any extra care you give them."

on health promotion — "Remember, to prevent is better than to cure."

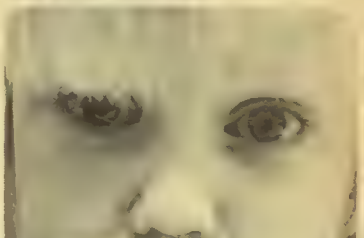
Finally, Hans has a few comments on the occupational hazards of his profession, some of which must sound familiar to nurses. Summers are short in Ottawa, he says, and during the "rush season" his staff work under tremendous pressure ... too much to do, not enough time to do it properly and not enough adequately trained people. In the winter, there is always the threat of unemployment.

On "bad days," the frustrations and uncertainties of this type of existence must seem overwhelming. What is it that gives him the incentive to keep on? One of his inspirations, he says, comes from a quotation by German philosopher Wolfgang von Goethe that has some bearing on the work that each of us has chosen, whether it involves caring for plants or people, "I know well enough that one does not receive thanks for what was made possible after the impossible was demanded — still and however, I will not refrain from undertaking the best I can."

— M.A.H.

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Herein



Courtesy Children's Hospital of Eastern

This month CNJ takes an informed and informative look at the care of the burn patient. The series of three articles starts on page 16.

In this issue, too, is something just a little different — an article that is intended only indirectly for CNJ nurse readers. "Laryngectomee Leaflet" was written by Deborah Vandewater for patients undergoing surgical treatment for cancer of the larynx. We hope that you will make use of this teaching tool in pamphlet form by passing it along to any of your patients who might use it.

Diabetes is a universal disease that is encountered most frequently in urban and industrialized countries, among older populations and generally in more affluent societies. In Canada, approximately 5% of our 23 million people are or will become diabetics in their lifetime. **Next month,**

- Elizabeth Laugharne describes Tri-Dec, the Tri-Hospital Diabetes Education Centre in Toronto and shows how three hospitals can pool their resources to provide a shared-cost educational program for diabetics and those who care for them.
- Author Elizabeth Crosby discusses the program at the Edmonton General Hospital Diabetic and Metabolic Centre and looks at the emotional adjustments of the parents and the diabetic child to the disease.
- Carol Polowich and Ruth Elliott of the University of British Columbia explore the unique problems of the adolescent diabetic.



Calendar

September

New Directions in Children's Mental Health International Symposium, co-sponsored by Thistletown Regional Centre for Children and Adolescents and the Department of Psychiatry, University of Toronto and The Hospital for Sick Children Foundation, on Sept. 14-16, 1977 at the Skyline Hotel, Toronto, Ontario. Contact: *Orville C. Green, 11 Farr Ave., Rexdale, Ont., M9V 2A5.*

The Nursing Process in Mental Health and Psychiatric Nursing to be held on Sept. 28-30, 1977 at the University of Toronto. Fee: $75. Contact: *Dorothy Brooks, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont. M5S 1A1.*

Infection Control: Basic Techniques. A one-day seminar sponsored by the Infection Control Nurses Calgary Group to be held in Calgary, Alta. on Sept. 30, 1977. Contact: *Ursula Ruskowski R.N., Infection Control and Staff Health Nurse, Alberta Children's Hospital, 1820 Richmond Rd. S.W., Calgary, Alta.*

Sexuality and the Disabled. A seminar sponsored by Planned Parenthood Newfoundland/Labrador. A three-day seminar to be held in St. John's, Newfoundland on September 22, 23 and 24. Resource persons are Beverley Thomas and Dr. Michael Barrett. Contact: *Barbara Collier, R.N., Planned Parenthood Newfoundland/Labrador, Fort William Building, Factory Lane, St. John's, Nfld.*

October

35th Annual Convention and Educational Programme of the Canadian Health Record Association to be held at the Four Seasons Hotel, Vancouver, British Columbia on Oct. 12-17, 1977. Contact: *Janet Milner, Executive Director, Canadian Health Record Association, 187 King Street East, Oshawa, Ont. L1H 1C3.*

Ontario Occupational Health Nurses Association Annual Conference to be held at the Connaught Hotel, Hamilton Ontario on Oct. 26-28, 1977. Theme: We believe in tomorrow. Contact: *Lorna Roche, Medical Centre, BP Refinery Canada Ltd., Oakville, Ontario.*

The Executive Nurse — a three-day program for nurses in management positions in acute-care facilities, chronic-care facilities, public health and occupational health organizations. To be held in Calgary, Alta. on Oct. 3-5, and in Toronto on Oct. 19-21, 1977. Tuition: $150. (Tax deductible). Contact: *R.M. Brown Consultants, 1115 - 1701 Kilborn Ave., Ottawa, Ontario, K1H 6M8. (613) 731-0978.*

American School Health Association 51st Annual Convention to be held in Atlanta, Georgia on Oct. 12-16, 1977. Contact: *American School Health Association, ASHA National Office, P.O. Box 708, Kent, Ohio, 44240.*

Annual Joint Meeting of the Canadian Heart Foundation, Canadian Cardiovascular Nurses and the Canadian Cardiovascular Society to be held at the Inn on the Park Hotel, Toronto on Oct. 17-18, 1977. Contact: *Mr. E. McDonald, Canadian Heart Foundation, One Nicholas St., Suite 1200, Ottawa, Ont., KIN 7B7.*

7th Annual Calgary Interagency Pediatric Seminar — "Their Future — Our Responsibility." A two-day seminar to be held on Oct. 20-21, 1977 in Calgary, Alberta. Fee:$25. Contact: *Nancy Clyne, Pediatric Nursing Coordinator, Foothills Hospital, Calgary, Alberta, T2N 2T9.*

The Treatment of Skin Disorders in Occupational, Ambulatory and Hospital Settings to be held at the University of Toronto on Oct. 20-21, 1977. Fee: $50. Contact: *Dorothy Brooks, Continuing Education Programme, Faculty of Nursing, University of Toronto, 50 St. George St., Toronto, Ont., M5S IAI.*

The Management of Motivation. A two-day program for all health care managers to be held in Calgary, Alta. on Oct. 6-7, 1977 at the Holiday Inn and in Toronto on Nov. 10-11, 1977 at the Royal York Hotel. Tuition: $120. (Tax deductible). Contact: *R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ontario, K1H 6M8.*

Getting Through to People. A two-day program for anyone who wants to become better at establishing personal relationships through the use of more effective communicating procedures. Enrolment limited. To be presented on Oct. 26-27, 1977 at the Royal York Hotel in Toronto. Tuition: $120. (Tax deductible). Contact: *R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ontario, K1H 6M8.*

International Conference on Cancer and Environment to be held on Oct. 13-14, 1977 at the Hotel Bonaventure, Montreal, Quebec. Contact: *The Secretariat of the Conference, Institut d' hemologie-oncologie de Montreal, Hôpital du Sacre-Coeur, 5400 Gouin Boulevard W., Montreal, Quebec, H4J IC5.*

November

17th Annual Conference of the Operating Room Nurses' Group of Quebec to be held at the Skyline Hotel, Côte de Liesse Road, Montreal on November 1-3, 1977. For further information contact: *Mrs. J. Verronneau, The Montreal General Hospital, Operating Room, 1650 Cedar Avenue, Montreal, Quebec.*

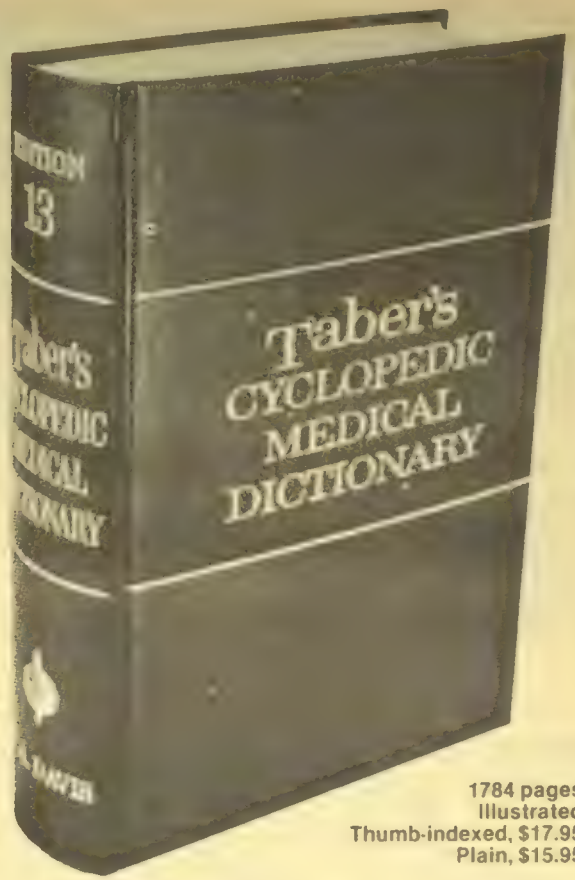
Critical Care Symposium sponsored by the Toronto chapter of the American Association of Critical Care Nurses to be held in Toronto on November 14-15, 1977. Contact: *Conference and Seminar Services, Humber College of Applied Arts and Technology, P.O. Box 1900, Rexdale, Ont.,M9W 5L7.*

21st Annual Symposium on Rehabilitation, co-sponsored by the Ontario March of Dimes and the Ontario Society for Crippled Children on Nov. 5, 1977 in Toronto. Contact: *The Ontario March of Dimes, 90 Thorncliffe Park Drive, Toronto, Ont., M4H IM5.*

Role Playing as a Teaching Method and a Therapeutic Technique to be held Nov. 3-4, 1977. Fee: $60.
Continuing Care of those who have come into End Stage Renal Disease to be held on Nov. 17-18, 1977. Fee: $50.
Intrauterine Assessment of the Fetus to be held on Nov. 15, 1977. Fee:$25.
Counselling the Emotionally Mentally Disturbed Patient Part 1 to be held Nov. 28 to Dec. 2, 1977. Fee: $125.
All courses to be held in Toronto. Contact: *Dorothy Brooks, Continuing Education Programme, Faculty of Nursing, University of Toronto, Toronto, Ont., M5S 1A1.*

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More than 12,000 nurses from all corners of the world attended the 16th Quadrennial Congress of the International Council of Nurses staged by the ICN in Tokyo from May 30 to June 3, 1977. The Congress theme, *New Horizons for Nursing*, gave participants and observers an excellent opportunity to discuss the latest trends in nursing education and practice and to explore how the nursing profession can increase its contribution to the overall planning and delivery of health care for all people.

ICN meets in Tokyo

Viviane Subervioia

In an atmosphere of friendliness and hospitality established by ICN's host association — the Japanese Nursing Association — registered nurses and students gathered in the huge Nippon Budokan Hall to witness deliberations of the Council of Representatives and hear papers and panel discussions presented by nursing leaders of the world.

The opening ceremony was held in the presence of Their Imperial Highnesses Crown Prince Akihito and Crown Princess Michiko and other Japanese dignitaries. The presidents and secretaries of ICN member associations, many of them wearing their native dress, were led in the traditional procession by Japanese nursing students.

Nine new member associations were formally welcomed to ICN membership: Fiji, Mauritius, Puerto Rico, Swaziland, St. Lucia, Paraguay, Sudan, Western Samoa and Honduras. "The significance of admitting these new associations to ICN membership reaches far beyond merely swelling the number of members ," said ICN president **Dorothy Cornelius.** "It means that the influence and colleagueship of nurses united in an international community has penetrated new territory, thus benefiting not only ICN and the new member associations, but also the people of their countries to whom they provide nursing services."

Following the admission ceremony for the nine new ICN members, 68 of ICN's 87 member associations responded to the roll call. Congress participants, who packed Budokan Hall to the top of its three tiers of balconies, were then aware that their congress had begun.

Congress participants were able to view nursing practice and talk with Japanese nurses at a series of visits to hospital and health facilities including a general hospital, ICU and CCU units, a children's hospital, a hospital for the elderly, a maternity hospital, a health center and a cancer center, as well as to educational facilities for basic, post-basic and specialized programs. Nursing exhibits arranged by the JNA, other member associations and ICN were displayed at the Science Museum, where films and video-tapes were also shown daily.

The busy week of speeches, debates, reports, questions and reactions of nurses from around the globe ended as Dorothy Cornelius passed the ICN chain to newly elected president **Olive E. Anstey** and left **Accountability** as her watchword for ICN.

Wearing the gold chain of office, composed of medallions bearing the watchwords of her predecessors, Anstey announced her two goals for the next quadrennium: the improvement of the social and economic welfare and status of nurses and nursing, and the promotion of more resources both financial and human to the further development of primary health care.

The 17th Quadrennial Congress is to be held in Kansas City, U.S.A.

Three plenary sessions on issues that confront the profession today took place during the congress. The sessions — on practice, education and professional responsibility — attracted capacity audiences and stimulated considerable sharing of information among the representatives of the various countries in attendance.

A report on two of these sessions — *What's New in Nursing Practice Around the World* and *New Dimensions of Professional Responsibility* — begins on page 38 of this issue.

The session concerned with *Changing Directions in Nursing Education* was broken into two parts, a debate and a panel discussion.

Debate centered on the assigned topic. "Resolved that technologically-oriented laboratories (programmed instruction, films, video-tapes, etc.) are superior to traditional forms (lecture, discussion, demonstration, etc.) for teaching nursing procedure."

Speaking for the resolution were **M. Josephine Flaherty,** dean and professor, Faculty of Nursing, University of Western Ontario, London, Ontario, and **Hiroko Usui,** professor, Department of Nursing Principles and Practice, School of Nursing, Chiba University, Chiba, Japan.

Speaking against the resolution were **Rosette-Aline Poletti,** director, Le Bon Secours School of Nursing, Geneva, Switzerland, and **Syringa Marshall Burnett,** lecturer, Advanced Nursing Education, University of West Indies.

Leading off the debate, Flaherty and Usui said that technology gives students an opportunity to pursue learning activities at their own speed and when they are ready to learn. This helps prevent boredom on the part of the quick students and frustration on the part of students who require more time for certain segments of their learning experiences. This method of teaching also gives students an opportunity to learn how to continue their education independently.

They also argued that technology provides an opportunity for teachers to use their time more effectively in order to meet needs of individual students and to put additional emphasis, if appropriate, on certain aspects of the curriculum.

Finally, it was felt that technological materials cost less and that the potential for use, re-use and combination with various types of materials are limitless.

Poletti and Marshall Burnett argued that in the field of nursing, it is not the techniques which are difficult to master, but rather the application of these techniques to human beings. Demonstration by a "flesh and blood" teacher and counter-demonstration under the guidance of the teacher make for individualized teaching. The teacher is able to be a role model, to act in the here and now, within the reality of the situation that the student is sharing and which is not always ideal.

The results? No official winner was announced but, as one of the judges remarked in her summary of the proceedings: "Traditional teaching methods and technology, used wisely, should complement each other. Technique is an extension of the human personality — not a replacement of it."

For the nurses in the audience, the session gave them the opportunity to share the reactions of representatives of a broad cross-section of countries and delegates. At one point, more than 30 nurses were lined up waiting for a turn at the mike.

Nursing education

Primary health care — what it is, its effect on the people who receive it and the preparation of primary care providers — was the subject under discussion by three panelists during the second half of the education session. The basic distinction between primary and secondary health care and the implications for nursing education were outlined by first panelist **Alice Akita,** Nursing Department, University of Ghana, Legon, Ghana. She defined primary health care as an approach that provides comprehensive, simple, inexpensive and effective services that are easily accessible to all members of a community, both sick and well, to improve their living and health conditions.

In contrast, secondary health care was defined as being a second level and specialized health care which operates within a referral system where patients are referred from the primary health care level for the attention of higher cadre personnel. It demands more sophisticated material and manpower resources and therefore is comparatively expensive.

"In contrasting primary and secondary health care, it has become obvious that in the face of world-wide economic crisis, primary health care appears to be the required approach," Akita said.

The panelist suggested that rural sociology, community organization, principles of community and health care be incorporated into the nursing curriculum, that nursing education shift its emphasis from urban to rural setting and that the nurse's role be redefined to correspond with the change of focus.

Two new types of nursing care that deal less with caring for the sick and more with keeping people well were described by **Madeleine Leininger,** dean and professor of nursing, University of Utah, Salt Lake City, USA.

Called primary and transcultural nursing care, the new methods "draw on the social sciences, the liberal arts and humanities to learn about normal, healthy and people-centered behaviors and to integrate or incorporate these knowledges into nursing instruction."

Concerning transcultural nursing, Dr. Leininger said "Nurses are beginning to discover that health care is largely culturally-determined, culturally-defined and requires cultural knowledge about people's values, beliefs and practices in order to provide effective, safe and satisfying nursing care to people of different cultural backgrounds." She predicted the full impact of transcultural nursing will not be realized in the US and elsewhere for another decade.

"Both primary and transcultural nursing have a generalist approach to assist people with their nursing and health concerns. Both should be based upon community and cultural life patterns to meet the diverse needs of people," she added.

Areas in which primary health care nurses should be skilled and the problems associated with their preparation were the topics of discussion by **Mo-Im Kim,** first vice-president of the Korean Nurses Association. "The nurse giving primary care must have broad-based skills in such areas as a knowledge of health and major deviations from it; an orientation to the family and community; a sense of colleagueship and accountability along with critical judgment which recognizes knowledge and the need for knowledge.

"In addition, skills in supervision and administration, an understanding of the primary health care delivery system and the roles of each of the professionals in it, and the ability to collect and analyze data and utilize the techniques of evaluative research are skills which the primary health care nurse must possess," she said.

→



Panelists

Panelists

USSR observers

Although the Soviet Union is not a member of the ICN, since there is no national nursing association as such in the USSR, two health professionals from behind the Iron Curtain did attend the ICN Congress in Tokyo as observers.

Natalia Vorobrva, a physician by education but now a 'trade unionist' by her own description, was one of them. At a press conference during the Congress she outlined the basic principles of health services in her country. "The aim of health care in the Soviet Union," she said, "is the promotion of active longevity." Prevention was a major theme of Vorobrva's comments. Socioeconomic and medical undertakings emphasize the prevention of diseases and the elimination of their causes. Much attention is devoted to the way of life, to the environment (air and water pollution, conditions of labor and humanization of industrial environment), to opportunities for rest and recreation and to higher spiritual standards of people. "The future belongs to preventive medicine; only social hygiene can cope with ailments of society," she said.

Health care was described as a team approach, with physician, nurse and other health care workers. Each territory has one or more polyclinics, according to population needs. A dispensary system has also been established as a special preventive measure for the early detection of disease, especially in those employed in industry. "It is easier to prevent than to cure," she commented.

"The salaries of doctors and nurses are parallel to those of heavy industrial labor workers," the observer said, "but we are trying to convince lay people that our work is more stressful than lifting in industries."

Programs leading to the basic nursing diploma are the only types of nursing education offered in the Soviet Union at the present time. The lack of university education for nursing is seen as a problem which has caused many people to turn away from nursing because they have the potential and desire for a university education. Vorobrva said that they hoped to learn from other ICN participants in the area of nursing education.

There is no separate national nursing organization in the USSR, but nursing is just one part of the total Medical Workers Union. Therefore, the Soviet Union has been in contact with ICN for a number of years, but is not a member of the Council of National Representatives.

Joining Vorobrva on the ICN visit was Ilga Bisenieik, matron at Paul Stradin Latvia Republic Clinical Hospital and chairman of the Council of Nurses, Latvia.

A grand total of 180 nurses including 15 Canadians took part in the 12 special interest sessions held during the Congress. Topics for these sessions were chosen to complement the plenary sessions on nursing practice, education and professional responsibility.

Representatives of the nursing profession in Canada served as moderators and panelists at several sessions, including two all-Canadian presentations on *The Changing Role of the Nurse* and *The Need for Higher Education among Nurses.* Panelists at the discussion on the changing role of the nurse included: **Irmajean Bajnok,** assistant professor, University of Western Ontario school of nursing, London, Ontario; **Stephany Grasset,** community health nurse, Vancouver, B.C.; **Rita Lussier,** consultant in continuing education in nursing, Montreal, Quebec; **Gladys Smith,** director of nursing service, Glace Bay, N.S. and moderator, **Rose Imai,** acting principal nursing officer, Health and Welfare Canada, Ottawa, Ontario.

"In order that educational programs continue to be relevant to the needs and desires of the population, nursing educators are faced with the dual responsibility of responding to the many different social, political and economic forces affecting nursing and also preparing nurses who can practice in the present, as well as in the year 2030," according to panelist **Irmajean Bajnok.**

Bajnok identified some of the factors that have affected and will continue to affect nursing education in Canada: the economic problems of providing health care to the masses, the increased focus on professionalization, consumerism, the increased political nature of Canadian society, and changing health needs of the population.

She outlined how nursing education has developed in the light of these external factors. "Our students are a more heterogeneous group; they are being prepared from a nursing and a health focus. More attempts are being made to teach collaboration or health team approaches to care.

"More than ever before, our nursing students are focusing on working together, respecting patients' rights and value systems, and promoting patient involvement in health care decision-making."

Panelist **Stephany Grasset** identified teamwork and technology as "cornerstones on which modern health care services are built — teamwork to provide adequate medical and health services for the forty million people who will populate Canada by the year 2000; technology to make the miracle of the computer work for medicine and bring safer, surer treatment to the masses.

"If nursing is to survive and grow as a profession, it has to keep abreast of technological advances, for the day is gone when the doctor was the only competent person to whom the patient could be entrusted," she said.

Referring to teamwork, Grasset explained that recognition of the many facets of primary health care has resulted in the proliferation of paramedical health workers, the nurse assuming a major role, both in the hospital and in the home.

Grasset identified some of the reasons and circumstances leading to the changing role of the nurse including: the lack of primary physicians, the increased proportion of elderly people, rapid urbanization and large areas of sparsely populated countryside, the widespread abuse of drugs and alcohol, increased violence and suicide, psychological disorders among both adults and children, the trend toward hospital admission for investigation and the use of hospital emergency departments for non-urgent and minor illnesses.

"Some nurses still think we should avoid change," she said, "But this is not possible. Nursing as a profession will change — either becoming more responsive to the people's needs for health care, or go the way of all changing conditions and become extinct.

"In recent years, Canadians have come to regard government services not as a privilege, but rather as a basic right," according to panelist **Gladys Smith** who supported her statement with vivid examples.

"I submit that if we place our emphasis on the area of human responsibility, introduce more monitoring and control, a positive approach to solving many of the inequities and injustices in the area of human rights could be achieved," said Smith.

"The nurse, in her many settings and skills, in collaboration with others in the health field, and provided a framework within which to move, is in a key position to act as a monitor and a counselor in health related responsibilities," she contended.

Fourth panelist **Rita Lussier** described continuing education as "the four corner meeting place" for nurses in order that they may better understand their role and identify the needs of the community they serve.

"Nurses must be able to identify what they need to learn" the panelist explained "as most nurses have trained in a hospital base, the orientation has been to hospital care. However, emphasis has shifted toward an expanded role of the nurse, both in the community and the hospital settings. More money is being spent for inservice education; it is up to the individual to take advantage of it."

Higher education

Panelists in the discussion on higher education consisted of Canadians: **Odile Larose,** director of the nursing sector, Order of Nurses of Quebec, **Nicole David,** clinical nurse specialist, Centre Hospitalier Maisonneuve Rosemont Montreal; **Marie-Thérèse Choquette,** director of professional education, Montreal; **Jeannine Pelland-Baudry,** associate professor, Faculty of Nursing, University of Montreal; and moderator, **Jeannine Tellier Cormier,** president of the ONQ.





Retiring ICN president **Dorothy Cornelius** *of the USA (above right) hands over the chain of office to Australian* **Olive Anstey** *who will serve as president for the 1977-81 quadrennium. In the photo on the left, Soviet observer* **Natalia Vorobrva** *(center) is pictured with ANA president,* **Anne Zimmerman** *(right).*

The Council of National Representatives (CNR) is the governing body of the International Council of Nurses and consists of the president (or proxy) of each of the ICN member associations — 87 as of June 1977. The CNR discusses international nursing issues and sets policy for the nursing profession. It operates on the democratic principle of one vote for each country represented.

CNR holds policy session

Highlights of the action taken by the CNR in Tokyo this year included:

- approval of a policy statement encouraging career mobility within the nursing profession (see box);
- approval of a policy statement on international migration of nurses (see box);
- approval of an operational statement and guidelines concerning the action of the nurse in safeguarding the human environment;
- approval of a revised statement on nursing research (see box);
- approval of a recommendation that ICN member associations study the (1974) WHO Expert Committee Report on Community Health Nursing and that associations undertake cooperative action with health authorities in order to further the provision of health care within the needs and resources of individual countries.

The statements and guidelines were presented to members of the Council of National Representatives as part of the Report of the ICN's Professional Services Committee on activities during the last half of its four-year term of office.

The operational statement on safeguarding the human environment approved by the CNR reiterates the ICN conviction that the contribution of nurses in this area is of such importance that national nurses associations should use every opportunity to encourage nurses at all levels to involve themselves, both as professionals and as citizens, in preserving and improving the environment. The guidelines that accompany the statement are directed to "nurses as practitioners, educators, administrators and citizens." The guidelines and operational statement support a policy statement on the role of the nurse in safeguarding the human environment adopted by the CNR in Singapore in 1975.

Other action

As the governing body of the International Council of Nurses, CNR members elected the 15-member ICN Board of Directors for the 1977-1981 quadrennium (see September CNJ). In addition, the CNR acted to:

1. continue its present system of dues assessment rather than adopt a sliding scale.
2. accept a resolution endorsing collective bargaining by nurses and recommending that member associations promote and maintain programs to prepare nurses "to utilize effectively the collective bargaining process as a means of resolving their employment concerns."
3. accept a proposal from Canada that the ICN consider the development of a position statement on "the role and responsibility of the nurse in alerting appropriate authorities to the high risk of disease transmission due to increased international travel."
4. accept a report from Cleo Doster, chairperson of the Student Assembly that met during the Congress.
5. Take note of a request from Canada that the Board review ICN's statement of purposes, objectives and functions to assess its relevancy and that the Board take whatever action is necessary.

INTERNATIONAL MIGRATION OF NURSES

Migration of nurses is an international phenomenon. Along with migration are the important issues of unequal economic and social developments which lead ICN to believe that measures should be taken to formulate realistic policies and plans of action.

ICN and its member associations support and promote high standards of nursing practice and therefore recognize and are concerned about the impact that international migration of nurses may have on the quality of health care.

The reasons and consequences of international movement differ from country to country.

ICN urges nurses associations to initiate and/or participate in a study of the phenomenon and examine national policies in regard to immigration and emigration of nurses, in order to:

- assess requirements for nursing manpower;
- maintain the high level of health care in the country;
- ensure that foreign nurses have qualifications equivalent to those required of nationals for licensure;
- assure that foreign nurses have conditions of employment which are not less favorable than those of nationals in posts involving the same duties and responsibilities;
- assist nurses with their problems in regard to international migration and



NURSING RESEARCH

The International Council of Nurses is convinced of the importance of nursing research as a major contribution to meeting the health and welfare needs of people. The continuous and rapid scientific developments in a changing world highlight the need for research as a means of identifying new knowledge, improving professional education and practice and effectively utilizing resources.

ICN believes that nursing research should be socially relevant. It should look to the future while drawing on the past and being concerned with the present.

Nursing research should include both that which relates to a total research plan and that which may be undertaken independently. In nursing research available resources of different levels of sophistication should be utilized and research should comply with accepted ethical standards. Research findings should be widely disseminated and their utilization and implementation encouraged when appropriate.

ICN believes that nurses should initiate and carry out research in areas specific to nursing and collaborate with related professions in research on other aspects of health. Nursing research should involve nurses practising in the area under study.

National nurses associations are urged to promote the development and utilization of nursing research in cooperation with other interested groups.

CAREER MOBILITY IN NURSING

Career mobility in nursing is the movement of nurses to more advanced levels of nursing practice, to different levels of nursing practice, or to positions in which different functions predominate. It must be supported and sustained by means of a related educational system.

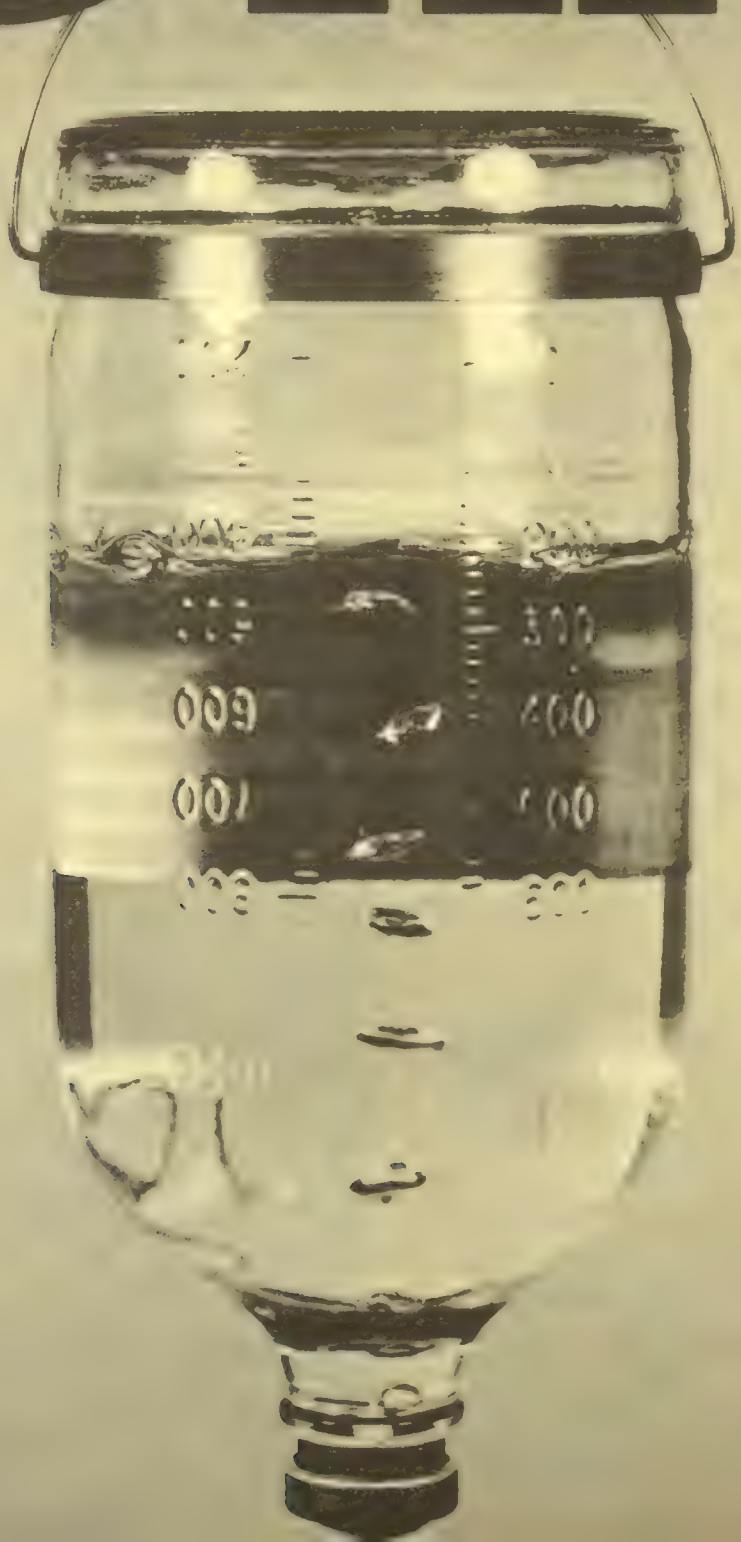
There are advantages in career mobility for the individual, the nursing profession and society. Career mobility enables nurses to achieve personal career goals within the limits of their ability. It contributes to the nursing profession by raising the competency of its members. Career mobility can forward society's aims of meeting the identified needs of the specific country by modifying or expanding the composition and supply of nursing personnel.

The increasing number of nurses interested in other nursing positions, the efforts of the nursing profession to promote expanding roles and the interest of governments in improving the level of nursing care in their countries — all carry an inherent commitment to provide the means for mobility in nursing. It is therefore essential that nurses associations, governments and other bodies facilitate the attainment of career goals by means of an articulated educational system that provides opportunity for nurses to move from one type or level of nursing to another. At the same time it is important not to lower the ultimate standards but to have a system that permits nurses to progress on the strengths of previous education and experience.

For such an educational system it is necessary to identify the core of knowledge, skills and scientific principles for first level nursing practice. The programs should be flexible and enable second level nurses to fill the gaps in their preparation in order to meet the requirements for first level nursing practice. First level nurses should be able to build upon their preparation in order to qualify for upward or lateral mobility into other clinical or functional areas.

ICN believes in the importance of career development within the profession. ICN calls upon its member associations to examine the systems of practice, service and education in their countries and to initiate or cooperate in the development of an educational system which will promote

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News

West Coast nurses stage 65th annual RNABC meeting

Health services, according to British Columbia's Minister of Health Robert McClelland, are among the things we take for granted now but may not be able to afford in the future unless we plan wisely and spend well.

McClelland, who was keynote speaker at the 65th annual meeting of the Registered Nurses Association of B.C., was making his first major address to the nurses in that province since assuming office two years ago.

"The health care system has been under great pressure, especially in terms of cost containment," said McClelland, "and many of your members are aware of that. I must let you know that I recognize the pressure that many of you have been working under."

But while acknowledging that "cost containment postures had some unpleasant effects," he asked nurses to "recognize that as a government we had few options. Our options still are somewhat restricted if we expect the health system to maintain its present shape and objectives."

McClelland described his ministry as "extremely interested" in the RNABC Quality Assurance Program which got underway a year ago. The health minister asked for "clear evidence that patients themselves are involved in the authorship of some standards. If we are serious about consumer participation, we have to involve the patient who, until recent times at least, has been assumed to lack the capacity to understand the complex basis of the illness and the treatment."

McClelland described the RNABC action in setting up a Labor Relations Division in 1976 as "absolutely essential" and noted "how pleased I am that RNABC has gone such a long way toward separating its professional and economic interests."

He said that the association's professional interests, as defined by the Registered Nurses Act, coincide with the public interest — the act reflecting the legislative view that RNABC is the best mechanism to govern nursing in B.C.

But McClelland declared that professional concerns should not be tied too closely to "economic interests, wages and salaries, working conditions, and so on. It is not really acceptable any more in the view of anyone responsible for the administration of public policy that there be an intertwining or intermingling of public and private interests."

"I appreciate that the separation of the labor relations responsibilities may have been painful, but it really was the only responsible route. I hope that those of your members who feel somewhat antagonized because of this move will realize that the only other option might have been total public control with the licensing authority vested directly in government."

Resolutions

Among the resolutions approved by voting delegates attending the annual meeting were ones dealing with the provision of emergency aid, public health programs, health promotion and health care planning. Delegates committed the association to:

- urge the Attorney General's Department of B.C. to introduce an "Emergency Medical Aid" Act, otherwise known as the "Good Samaritan Act," to protect those rendering emergency aid at the scene of an accident from liability.
- make known its belief that the quality of public health nursing services in the Province of British Columbia is severely affected by the restrictions placed on the hiring for vacated public health nursing positions; and request the Ministry of Health to lift the hiring "freeze" for the vacated public health nursing positions.
- seek from the Premier of B.C. a statement outlining the direction that health care for the province will take in the future
- urge the provincial government to notify the RNABC of any intent to create new facilities for housing both the well and ill elderly population.
- consider a move to make experience in specialty areas, namely the operating room and the emergency room, compulsory in all programs preparatory to nurse registration in B.C.

Executive committee

Three Vancouver nurses will hold top offices in the RNABC over the next two years. They are president Sue Rothwell; first vice-president, Stephany Grasset; and second vice-president Lois Blais.

Under by-law amendments adopted at the annual meeting, a new executive structure, expected to take effect later this year will see Rothwell continue as president, Grasset serving as vice-president and Blais becoming a director-at-large.

The trio was elected in a province-wide mail ballot this spring that drew the highest association voter participation in recent years. Some 37 per cent of the membership voted this year, compared to 26 per cent in 1973, the most recent contested election.

President's address

Retiring president Thurley Duck, addressing RNABC members at the conclusion of her term of office, focused her remarks on the relationship between the professional association as a whole and the newly established Labor Relations Division. Although there are differences in priorities, role definitions and strategies, she pointed out, the two facets of organizational life reflect "very necessary efforts towards the general goals of increased earnings, professional autonomy, prestige, high quality work performance, and a sincere concern for service to individuals and groups of people in our province.

"It would be ludicrous to believe that the union side of our organization (and yes, union is a legitimate word to use) does not have any interest in standards of nursing practice, safety-to-practice, education of nurses both basic and continuing, relationships with government, discipline, and all of those other matters of concern to the association. It would be equally absurd to believe that the so-called professional arm is not at all interested in the regulation of relations between employers and employees through collective bargaining. To adopt either of these stances, one in prime favor over the other, would have the very definite effect of denying reality."

Quality assurance off to flying start

Close to 1000 Saskatchewan nurses have participated in a series of workshops and meetings connected with the SRNA quality assurance program since it was launched ten months ago.

The goal of the five-year program is the improvement of nursing practice. The long-range plan is to establish standards and criteria of nursing practice, implement ongoing evaluation, and effect improvement action. Professional accountability will be demonstrated.

Since September, 1976, a total of 989 nurses have attended either the one-day or two-hour sessions on quality assurance given by SRNA nursing consultant, Marjorie Hewitt. Workshops are on a voluntary basis and are sponsored by individual hospitals, regions or local chapters.

Pediatric audiology workshop aids nurses

A workshop on pediatric audiology, attended by public health nurses and RNA's from Ontario, Québec, New Brunswick and Prince Edward Island, was held at Queen's University in Kingston, Ontario early in June.

Coordinator of the event was Marie Heintzman, head audiologist, at Kingston General Hospital. This year's workshop was the fourth to be organized. The 1978 workshop is scheduled for the week of June 5th.

The week consisted of 20 hours of intensive lectures on such topics as anatomy and physiology of the ear, pathology and treatment, psychological implications of deafness, embryology of the ear, genetics of deafness, audiological assessment of children from birth to six years, optimal usage of hearing aids, and interdisciplinary assessment of the additionally handicapped child. The nurses also received approximately 15 hours of practical training in hearing screening of elementary school children, babies, hearing impaired children and mentally and physically handicapped children.

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News

NS nurses attend 68th annual meeting

"The responsibilities and demands may be heavy but the rewards for active participation in your professional association far outweigh the contribution,"**Gladys Smith,** president of the Registered Nurses Association of Nova Scotia told members attending the association's 68th annual meeting in Sydney in late June.

"Health Care in Nova Scotia — Is There a Crisis?" was the theme of the meeting and was the topic discussed by a symposium consisting of representatives of government, hospital administration, and the nursing and medical fields. It was the consensus of nurses participating in the discussion that government planners of health care are not taking the long-term view nor are they consulting with those who form the largest body of health professionals, the nurses.

Rose Imai, acting Principal Nursing Officer for Health and Welfare Canada, spoke on the new federal-provincial financing arrangements and their implications for health care and also outlined the proposed federal Social Services Act. She faced a barrage of questions from those present. A resolution passed later by the RNANS asked that the association keep members well informed on the implications for nursing of all intended or actual legislation concerning health matters.

Glenna Rowsell, recently appointed director of Labour Relations Services for the Canadian Nurses Association, spoke on "The Professional Association and the Union."

"Perhaps the most vital question to be answered is how can we wear two hats and look well in the eyes of the profession and the public," she said and described the real issue as "how can the professional organization and the union function in their respective roles and also work together in the name of nursing?" Working together, she emphasized, can give strength to *both* groups.

Three amendments to RNANS by-laws were passed. These had to do with raising the current registration fee from $50 to $75, requiring all members to carry malpractice insurance, and empowering the executive to levy an additional fee each year as a premium for the insurance.

Life Membership was bestowed on **Florence Gass,** who recently retired as Director of Nursing Services at the Victoria General Hospital, Halifax after more than twenty years service.

The Award of Merit was given to **Dr. Jane Haliburton** for her contribution to nursing education in the province.

Ten resolutions were passed; three requested government to make seat belts mandatory, to establish standards for ambulance vehicles and training of ambulance attendants, and to upgrade standards for fire safety procedures for senior citizens wherever they may reside. Other resolutions called for a petition to be prepared for the Minister of Health and the Minister of Social Services to utilize more effectively registered nurses in the promotion and maintenance of health in N.S., and a request to be sent to the Minister of Health that when opportunities become available that the skills of qualified women in high level positions be utilized on Boards and Commissions in the health service.

Did you know ...

Cases of leprosy — once considered a world scourge — have tripled in Canada within the past 12 years. A total of 99 cases were reported in Canada in 1976, up from 38 in 1965. Two-thirds (68) of the cases were in Ontario, with the remainder distributed across the country from B.C. to Newfoundland.

The Canadian Nurses Association is holding its annual meeting and biennial convention for 1978 on June 25-28 in Toronto's Royal York Hotel. For information contact: *The Canadian Nurses Association, 50 The Driveway, Ottawa, Ontario, K2P 1E2.*

Margaret Nixon heads Manitoba interest group

Nurse practitioners in Manitoba have joined forces to create an active organization that, within the past year, has prepared a brief addressed to the government of that province and organized three educational seminars. Although membership in the group remains small (approximately 16 prepared nurse practitioners and 10 nurses functioning as primary care providers), the seminars have been enthusiastically received.

Speakers at the most recent seminar covered a variety of problems occurring in primary care settings including: pregnancy, rape, emergency care, alcoholism and child abuse.

Dr. John Warrington, Department of Allergy and Immunology, Health Sciences Centre, Winnipeg, discussed present trends in the identification and treatment of patients with allergy. He pointed out that allergy desensitization is still fraught with many problems, the most serious being the possibility of an anaphylactic reaction; treatment now recommended includes desensitization only after more conservative management has not been effective.

Child abuse was the topic of an address by Dr. Ken McRae, director, Child Development Clinic, Children's Centre, Winnipeg. He encouraged nurses to consider early identification of a potential abuse situation, e.g. during the pre- or immediate post-natal period, protection of the child and rehabilitation and support of parents, as primary objectives in dealing with this problem.

Dr. Bill Davidson, associate professor, Department of Therapeutics and Pharmacology, University of Manitoba, related the recent research experience involving the use of Antabuse implants in the treatment of alcoholics. His study to date has demonstrated promising positive results with the experimental group of alcoholics with implants reacting to alcohol intake and a high percentage subsequently staying dry, the control group not reacting and returning to drinking again.

Many nurses in rural Manitoba provide emergency care at the scene of roadside and other accidents. Dr. Gerry Bristow, Director, Casualty,Health Sciences Centre, Winnipeg, discussed trends in emergency care emphasizing maintenance of the airway in unconscious accident victims, the value of expertise in cardiopulmonary resuscitation and safety when moving patients.

Christine Rollo from Pregnancy Information Service, and Francis Karpa, Rape Crisis Centre, explained the services of these Winnipeg-based groups. Nurses were encouraged by both speakers to contact their groups for either consultation or referral when dealing with patients requiring help.

The seminar concluded with a business session during which Margaret Nixon accepted chairmanship of the group, succeeding Lynn McClure. The group plans to hold their next seminar in November, 1977.

ICN seeks director

The International Council of Nurses is now accepting applications for the position of executive director of the ICN. The successful candidate will be expected to assume the position by January 1, 1978 and to reside in Geneva while filling the position.

Criteria for eligibility include:

- membership in a national nurses organization (ICN member);
- fluency in English and good working knowledge of French or willingness to learn;
- up-to-date nursing knowledge;
- international work experience;
- managerial and leadership skills and experience.

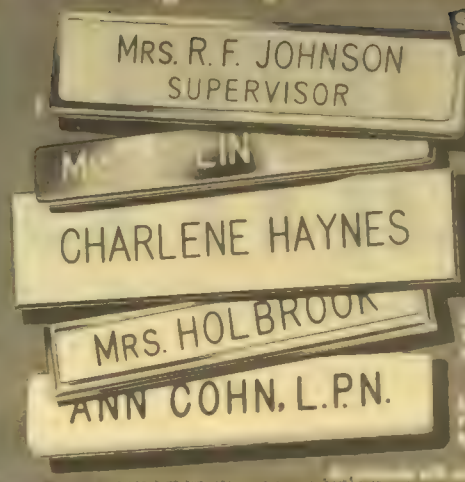
Applications should include a detailed statement of experience, education and professional activity and give the names of three referees, including the present employer and the national nurses association.

Applications, typed in duplicate, should be addressed to: *Miss Barbara N. Fawkes, Executive Director, International Council of Nurses, P.O. Box 42, CH-1211, Geneva 20, Switzerland, and the envelope marked: "Application — Executive Director."*

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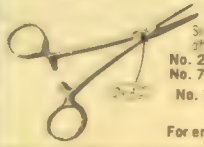
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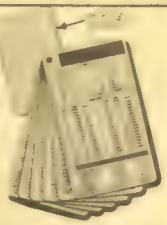


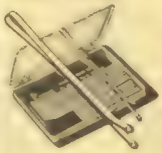
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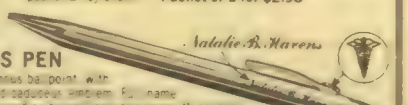
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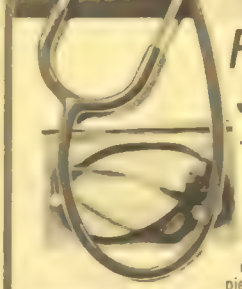
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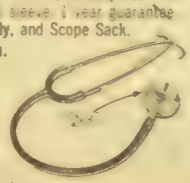
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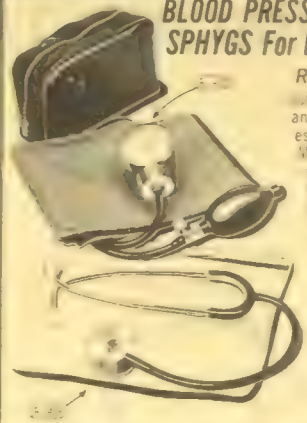
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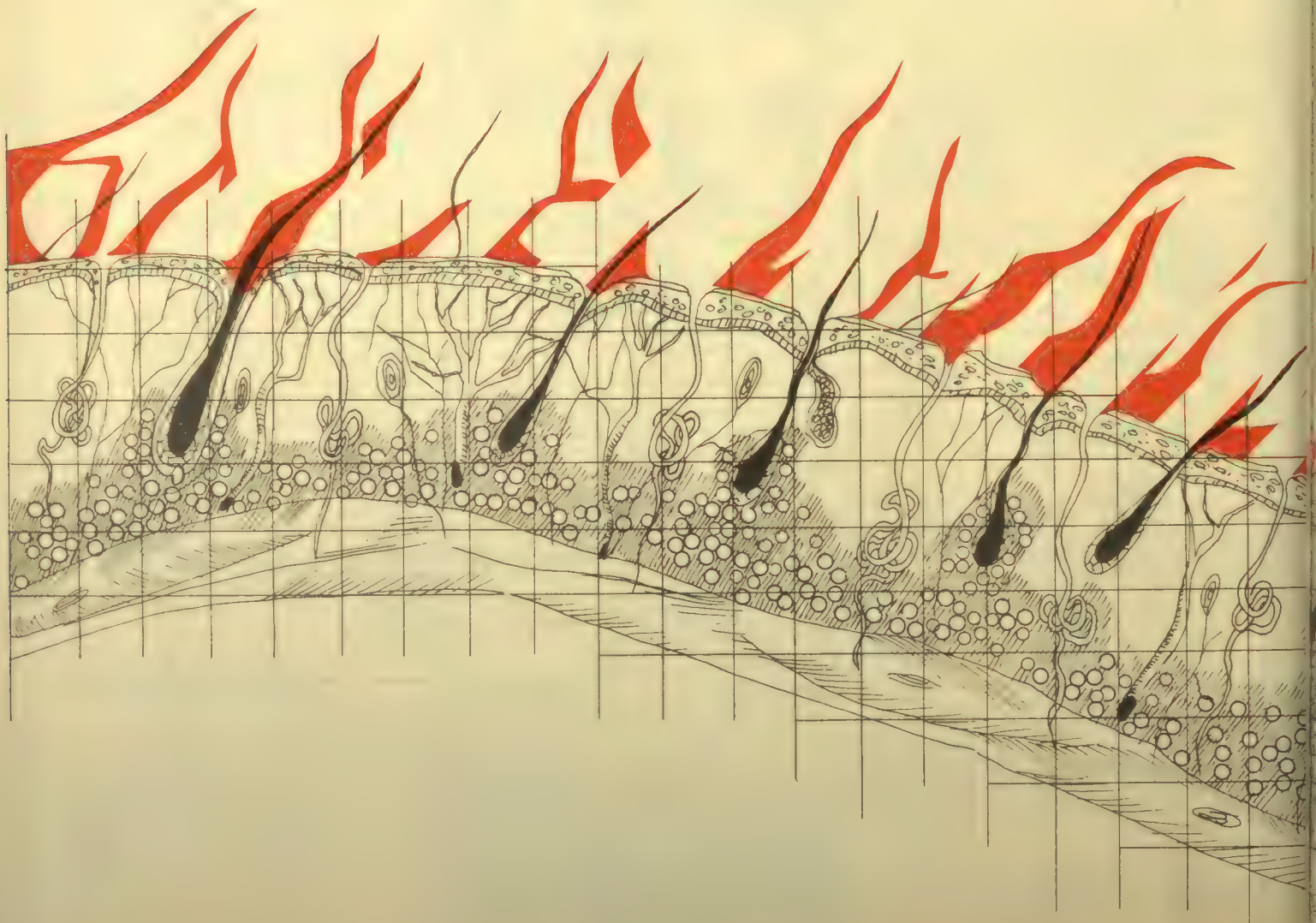
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Burn Update

What you need to know about burns

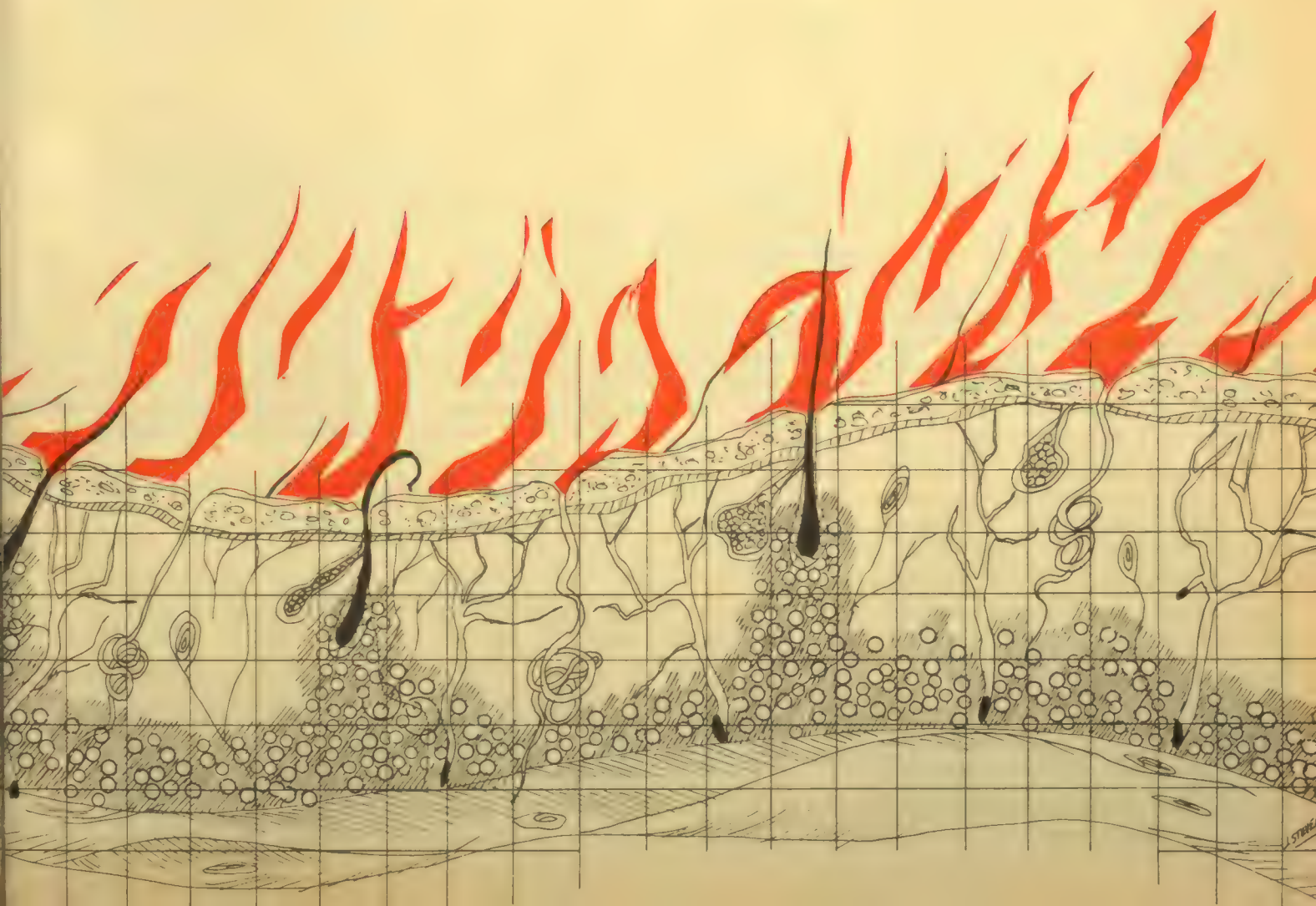
Sandra LeFort



You are a nurse working in a small rural hospital. Your head nurse has been asked to send one of her staff to the emergency department to help care for patients who are on their way in from a fire. You are sent. Going down in the elevator, you try and remember what is most important about treating these patients. Your contact with burn patients has been minimal, though — in fact, you recall that only once as a student did you have to look after a patient with a severe burn. The most vivid memory is the smell of a pseudomonas infection growing under the eschar — an odor so strong that it seemed to permeate the whole room. But what else? You recall some priorities of care — patent airway, I.V. fluid , lots of it — but still as you step off the elevator, you ask yourself — what is really happening to the patient with a severe burn?

Caring for a patient with burns is a task that requires you to have some knowledge of the fundamental pathological, physiological and psychological changes that can occur. There is no mystique about good burn nursing, only a need to understand and to be aware of what is going on. The proper utilization of this knowledge will enable you to give good nursing care to patients with burns.

If you are that nurse in the elevator wondering what happens to a burn patient, what the priorities of care are, what treatment he should receive, this article should be of some help. It is a review of the basics of burn care with some new ideas on treatment and nursing care. We might all be that nurse one day.



Burn Update

First Aid

The most common burns are thermal, those caused by fire, hot objects or hot liquids. If you are the person at the scene of a burn accident, your immediate management of the burn or scald will depend on the site of the burn injury and the setting in which it occurs, whether at home, place of work or outside. Remember that the most important factors are the area and extent of the burn rather than the depth. Also, burns in the very young or very old, even though small, should be considered serious and hospital treatment should be sought.

In general, the following guidelines should be followed:

1. Eliminate the cause of the burn by smothering the flames, switching off the current etc.

2. Check the respiratory status of the person. If the fire was in an enclosed space, suspect respiratory problems. *Listen to the person breathe.* Is he wheezy? Does his chest feel tight, sore or burning? Is he coughing and gasping for air? Are his face and nostrils singed with soot? Are nasal hairs singed? If the answer is yes to any of these, then smoke has probably entered the lungs, a condition that can result in irritation, pulmonary edema or respiratory failure. Removal of the person to a fresh atmosphere and/or mouth-to-mouth resuscitation may be necessary. Be sure that clothing does not restrict chest movements.

3. Make the victim comfortable. If the burns are extensive, the victim should lie down. If there is respiratory involvement, elevate his head.

4. Treat the burn wound. If the burn is small such as a scald from hot liquid, immediately immerse the part in cold water or flood it with water. This is the only treatment that has been found to decrease the degree or depth of a burn. It will also ease the pain. At all costs, avoid smearing the area with greasy or powdery preparations such as butter, soap or flour. These trap heat and may increase the severity of the burn. If blisters are present, do not break them.

When the person feels some relief, remove the part from the water and cover with a dry dressing or anything clean such as a towel. Bandage the area securely but loose enough to allow for edema. Before bandaging, remove any jewellery or anything restrictive that will impair circulation in edematous areas. If fingers or toes are burned, bandage each digit separately leaving the tips exposed. Check for warmth of fingertips.

If the patient has deep burns, do not try to remove charred particles or clothing. To relieve pain, apply cold, wet compresses.

If a large body area is involved, treat for shock by keeping him warm. Wrap the victim in clean sheets and blankets to prevent chilling, to reduce the risk of contamination and to conceal bad burns from him.

5. Give oral fluids in limited quantities only if the person has severe burns, is conscious and not vomiting and if medical assistance will be delayed. Often, victims will be very thirsty. The ideal solution to give is Haldane's solution — one teaspoon of salt and one-half teaspoon of sodium bicarbonate (baking soda) in one quart of water. Give only one or two ounces at a time. Check for vomiting and aspiration.

6. Stay with the patient and provide emotional support until an ambulance or other assistance arrives.

Chemical burns

Accidents involving corrosives are met most commonly in industry and can be very severe. In all cases, seconds count. Remove any saturated clothing while flooding the area repeatedly with water. Prolonged drenching under running water is essential to remove the corrosive. Most industrial plants also provide buffer solutions that can be applied after the water.

Eye burns are also treated by drenching with water. The eyelids must be opened to allow the water to be poured into the eye. Eye burns are particularly frightening and the patient needs to be told that the water will ease the pain and that help is on the way. Bandage both eyes with a dry sterile gauze if available.

Electrical burns

Electricity can cause burns or burn-like tissue damage from the heat generated from electrical sparks and arcs, or by an electric current passing directly through the body. Electrical burns may cause cardiac arrest due to ventricular fibrillation. Muscle spasm may throw the victim away from the point of contact and cause other injuries such as broken bones. Initiate CPR if breathing and heartbeat have ceased. Otherwise, treat as for thermal burns.

Skin

A severe burn constitutes a major threat to life. It disrupts the integrity of the skin and consequently can have an effect on every major body system. As the largest organ in the body, the skin is a complex combination of tissues that serves:

- to protect the body from infection and injury
- to prevent loss of body fluids
- to regulate body temperature
- to excrete wastes through perspiration
- to synthesize vitamin D and absorb drugs
- to provide a cosmetic effect for the individual, playing a large part in his self-identity and body image
- to act as a sensory organ.

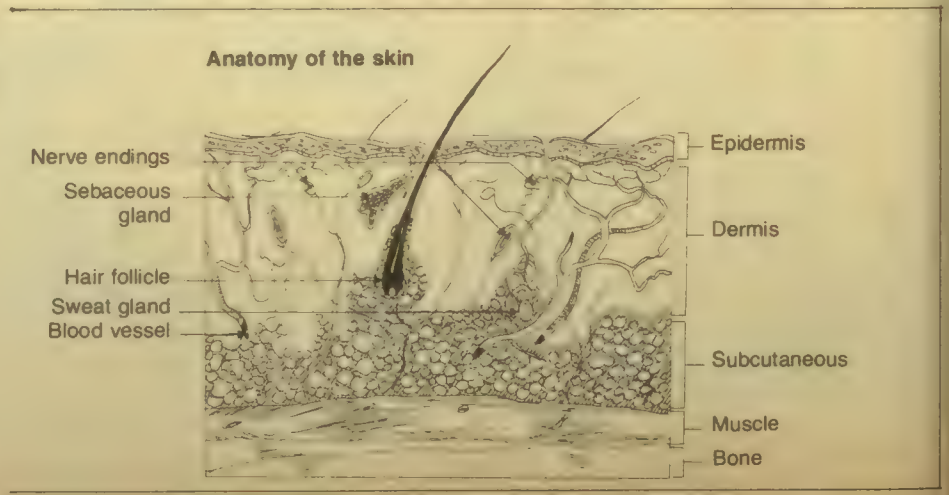
A severe burn results in decreased function or complete loss of the two most important life-preserving functions of the skin: *protection from infection and fluid loss.*

The skin or integument consists of two main layers: the epidermis and the dermis. The thin surface layer of the skin is the epidermis. It is non-vascular consisting of distinct layers of epithelial cells, which when mature, cornify to form a protective layer of dead cells. In burns, excessive fluid and electrolytes are lost due to damage of the stratum corneum, the outer epithelial layer. The innermost epithelial layer, the stratum germinativum, provides for the natural regeneration of epithelial cells. These cells must be present if new skin is to grow. (See Figure 1)

The epidermal appendages — the hair follicles, sebaceous glands and sweat glands — extend into the dermis, the second anatomical layer of the skin. These appendages are surrounded by a thin layer of epithelial cells from the stratum germinativum that can provide for skin regeneration.

As the supporting and nutritional layer for the epidermis, the dermis contains a large blood supply and nerve endings; it is composed mostly of collagenic fibers. If this layer is injured, perception of pain, temperature and tactile sensation is destroyed or impaired. If a burn reaches this level, collagen leaks from the surface of the burn wound providing a rich nutritional medium for bacterial growth.

Figure 1



Assessment of burns

One of the first considerations in caring for the patient with burns is to determine the extent and severity of the injury. Treatment of the burn is directly related to severity which is influenced by five factors:

1. Size of the burn. This is expressed as a percentage of the total body area. The "Rule of Nines" is a quick method of estimating the extent of body burns in the adult. The head and each arm count as 9%; each leg, anterior trunk and posterior trunk count for 18%; perineum counts for 1%. This method however tends to be an overestimation of the size of the burn.

A second method by Berkow, is more accurate and accounts for change in proportion by age. For example, Berkow's chart takes into account that a child's head is proportionately twice as large as an adult's.

Both these methods require the use of diagrams, shading the burned area, both anterior and posterior, and from that, calculating the percentage of body burned. All emergency departments should have charts available for quick assessment.

2. Depth of the burn. Current terminology expresses depth of burn as full-thickness or partial-thickness, rather than the old classification of first, second, and third degree burns. A *partial-thickness* burn can involve the epidermis and part of the dermis and is able to heal without grafting. New skin can resurface from epithelial cells. This is equivalent to a first or second degree burn. A *deep dermal* burn is a partial-thickness burn that frequently has the gross appearance of a third degree or full-thickness burn. It can heal without grafting since epithelial cells remain around hair follicles and sweat glands in the dermis. Often, infection, trauma or a decreased blood supply converts the burn to a full-thickness burn if skin grafting is not done. A *full-thickness* burn always requires grafting. The entire dermis is destroyed along with possible damage of muscle and bone. (Figure 2)

3. Location of the burn. Burns to the face, hands, neck, external genitalia and joint surfaces are considered severe burns. Any burn to the upper body is more serious than to the lower body.

4. Age. The young and old are particularly susceptible to the complications of burns such as septicemia, respiratory problems, renal failure etc. If a young person sustains burns but was previously healthy, he has a good chance of surviving no matter how large the burn.

5. Presence of other diseases such as respiratory and heart disease, as well as any chronic condition will complicate treatment.

The severity of the burn, the treatment initiated and the patient's chance of survival are dependent on all these factors. In general, a burn of more than 10% of the body which includes face, hands, feet or genitalia is considered a major burn and will necessitate hospitalization.

Most often, the initial assessment of a burn patient will take place in the emergency department. If there is a burn unit in your hospital or if private rooms are available for burn patients, he will be transferred after the initial assessment. If you receive the patient from emergency, be sure that tetanus prophylaxis has been given.

Hospital personnel tend to be overwhelmed when confronted by a severely burned patient, perhaps because of his appearance. However, for the burn victim who has no other injuries, treatment is not difficult to initiate because priorities of care can be anticipated in the immediate post-burn phase, sometimes called the emergent phase. Some emergency departments have pre-established regimes of treatment and may have a 'burn cupboard' or cart that contains all the necessary equipment for immediate burn care. Certain wards in hospitals that are set up for burn victims also have a burn supply cupboard for easy access.

Figure 2

Classification of burn wound	Depth	Appearance	Healing
First degree partial-thickness burn caused by exposure to sun, hot liquids.	epidermal layers	— red or pink — slight edema	Epidermis peels in 3-6 days. No scarring.
Second degree partial-thickness burns caused by intense flash heat, contact with hot liquids or objects.	epidermis and dermis	1. Superficial — mottled, pink or red — blistering and edema — moist 2. Deep dermal — varied appearance red, dull white, tan in color. — reddened areas blanch on fingertip pressure and then refill	10-14 days with no scarring if it has remained clean and untraumatized. Several months to heal on its own. Often, grafting done to provide more durable skin coverage and better function.
Third degree full-thickness burn caused by fire, chemicals.	no visible epithelial cells left. Down to the dermal and sub-dermal level	— blistered — can be moist or dry — white, tan, brown, black or red in color — red areas do not blanch on pressure — wet or dry and has a sunken appearance — due to surface dehydration, eschar (leathery covering) may appear — black networks of coagulated capillaries seen	Grafting required with split thickness skin grafts. Skin grafts done as soon as condition is stable and skin is available.
Fourth degree full-thickness burn.	subcutaneous fat, fascia, muscle and bone.	— blackened and depressed — when the burn includes bone, it appears dull and dry.	To achieve a granulating surface on which to apply a skin graft, fenestration must be done (multiple perforations reaching into the marrow cavity of the bone).

To test for depth of burn injury, try the **HAIR TEST.** If hair can be pulled out, then it's probably a full-thickness burn.

Priorities of Care

1. Respiratory needs are the first priority. If the patient inhaled smoke or if he has burns to the face and neck, anticipate respiratory difficulties. Gas or smoke inhalation can result in irritation to the lungs, pulmonary edema, pneumonia and respiratory failure. Check vital signs frequently especially noting changes in the respiratory or pulse rates. If the patient is not "shocky" and experiences difficulty in breathing, place him in the Fowler's position, give humidified oxygen and suction gently as necessary to remove secretions. Have the patient cough and deep breathe to keep the lungs well oxygenated. Blood gases should be taken to assess respiratory function.

If a patent airway cannot be maintained, the insertion of an endotracheal tube may be necessary or a tracheotomy may be performed as a last resort. Within 24-48 hours, edema resulting from a circumferential burn to the neck or chest may squeeze the trachea and rib cage and thus compromise breathing. Any circumferential burn (a burn that completely encircles an area) can act as a tourniquet and impair circulation or, in the case of a neck burn, close off the trachea. An escharotomy may be done to relieve the pressure. In this procedure, the doctor cuts the skin along the neck lines until bleeding occurs, thus releasing the pressure of the edema on underlying structures.

2. Check for hemorrhage. Patients who have sustained burns from automobile or other accidents must be checked for injuries that can result in hemorrhage. The burn wound itself causes only minimal blood loss, so if bleeding is evident, suspect a laceration or internal bleeding. X rays and other tests may have to be done at this time.

3. Prevent shock by meeting fluid needs. By the time a burn victim arrives at the hospital, he may already have lapsed into primary or neurogenic shock. Lasting only for about 20 minutes immediately following an injury, it can manifest itself as intense fear, terror and pain. Vasodilation causes a fall in blood pressure and an increased heart rate. This state frequently occurs in adults with severe burns and may be fatal.

The more common cause of shock in burn patients, however, is hypovolemia or loss of circulating fluid, a state often called "burn shock." It is the most crucial period during burn treatment and is characterized by a major shift in body fluid and electrolytes from the intravascular and intracellular spaces into the interstitial spaces.

Why a fluid shift?

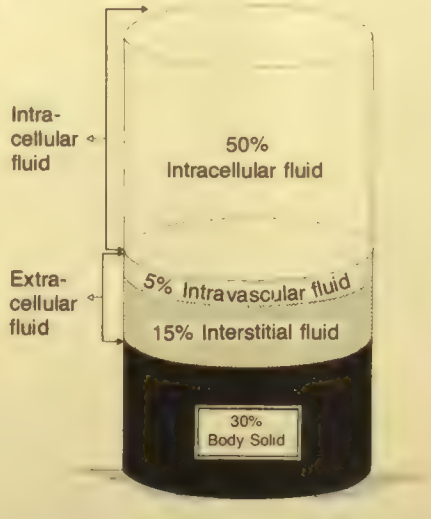
In the body, 50-70% or two-thirds of body weight is water, distributed into three compartments: the intracellular, interstitial and intravascular spaces (See Figure 3). Normally, the fluid in these compartments is constantly exchanged through a process of diffusion and filtration that occurs in the capillary bed. It is at this level that oxygen and nutrients are exchanged for waste products. The capillary membranes through which this exchange takes place are freely permeable to salt and water and selectively permeable to proteins and other matter.

Maintenance of fluid volume within each compartment is due to: *colloidal osmotic pressure* — a pulling force exerted by proteins on one side of the membrane that tends to keep fluid in the intravascular space or blood vessels; and *hydrostatic pressure* — a pushing force at the arterial end of capillaries that tends to drive fluid into the interstitial spaces. These two opposing forces prevent undue loss of fluid from the capillaries. Electrolytes, found in all the fluid compartments, play a large role in maintaining the fluid balance as well.

In a burn injury, capillary dilation and an increase in capillary permeability occur, resulting in a fluid shift. Plasma, electrolytes and plasma proteins escape from the intravascular space into the interstitial space. Edema is the end result with blister formation in some areas. The lymphatic system, usually able to take away the increased tissue fluid, quickly becomes overloaded and is unable to remove the excess.

This fluid shift continues for 24-48 hours depending on the extent of the burn. The body tries to compensate for the loss of blood volume by vasoconstriction, increased heart rate, decreased cardiac output, decreased blood flow and oliguria. It is essential that fluid replacement be initiated before shock occurs.

Figure 3



Fluid compartments of the body in an adult male

On admission, one or more intravenous lines are started and fluid therapy is initiated. Many different formulas have been developed to calculate the approximate fluid requirements but most use a combination of colloids, crystalloids and water solutions. Often, Lactated Ringer's solution (which has a similar electrolyte balance to blood) and albumin (to increase colloid osmotic pressure) are used. Vitamins B and C are often added to the I.V.

If possible, weigh the patient or ask a family member the pre-burn weight of the patient. This helps in calculating fluid requirements. Well treated burn patients often show a weight gain of 10-15% during initial treatment.

The most important indicator for deciding on how much fluid should be given is *titration,* that is, maintaining a careful balance between intake and output to maintain normal vital signs. In other words, you need to give enough fluid to keep the urine output at 30 cc/hr. In the initial post-burn period, a severely burned patient may need massive amounts of fluid e.g. up to 1,000 cc of fluid in one hour to establish adequate intravascular volume.

On admission, a catheter must be inserted and urine output and specific gravity of the urine checked every hour. Hematocrit should also be taken every four to six hours to determine red blood cell concentration. The hematocrit rises immediately after a severe burn and then decreases to preburn levels with adequate fluid replacement. Anemia may develop later as a result of RBC destruction due to thermal injury.

In two to five days, this fluid process will reverse. The capillary endothelial cells regain their normal permeability and edema subsides as the fluid returns to the intravascular space. At this point, a massive diuresis occurs. There is a subsequent rise in blood volume, an increase in cardiac output and a decreased hematocrit due to hemodilution. There is a danger of pulmonary edema or cardiac failure at this time due to fluid overload and change in electrolyte balance. This diuretic phase is a sign that the body is starting to repair the damage.

Although fluid replacement is of primary importance, patients with major burns should not be given fluid by mouth for the first two days. Burn patients tend to develop a paralytic ileus and may develop a stress ulcer, called Curling's ulcer. Frequently, a naso-gastric tube is inserted and Maalox given every two-three hours.

After diuresis there is a period of negative nitrogen blance and a reduction of protein levels in the blood. A high-protein, high-calorie diet should be started as soon as the patient can tolerate it, usually by the fourth or fifth day post burn.

During the initiation of life-saving measures, the burn patient and his family need reassurance about his condition. Burn patients are conscious (unless there are other injuries that render them unconscious) and are often

extremely frightened, and in pain. Although full-thickness burns are painless, most patients have a mixture of partial and full-thickness burns, and thus require pain medication. Small doses of morphine I.V. are given to reduce the pain and to act as a sedative. Large doses of sedatives and analgesics are avoided since they will mask signs of respiratory depression. The patient also needs frequent explanations about what is being done and reassurance that the pain will ease.

An initial dose of antibiotic, usually penicillin (unless the patient is allergic to it) is given on admission as prophylaxis against B-hemolytic streptococcus.

4. Care of the burn wound. Sepsis or infection rates high as a cause of mortality in burn patients. With the loss of skin integrity, these patients are extremely susceptible to massive infections. All staff must maintain strict sterile technique when in direct contact with the patient. Good handwashing cannot be stressed enough.

Local care of a burn wound is often left until the patient is transferred to a unit or a private room. Local wound care can be delayed up to four hours post-burn. If cleansing is left until then, the patient should be wrapped in a sterile sheet and covered with a blanket.

On arrival to a ward or unit, the patient is put on protective isolation. If possible, the patient is placed in a bathtub (or hydrotherapy tub or Hubbard tank) for cleansing. Special plastic liners for tubs are now available. The wounds can be washed in the tub with water and mild detergent . Washing should be done gently to remove debris. Never scrub a burn wound since this could convert a partial-thickness to a full-thickness wound. Dead skin that can be removed is debrided in the tub at this time but blisters are left intact unless they interfere with joint function. If necessary, the blisters can be punctured and deflated but do not unroof them. Also, hair near the burn wound should be shaved since it tends to harbor bacteria.

This initial cleansing of the wound provides an opportunity to re-evaluate the burn wound itself — its size, extent and appearance. Look closely for circumferential burns that may require an escharotomy. This is a good time to weigh the patient if this has not been done before. A weight increase is expected due to fluid replacement. Swabs of the nose, throat, rectum and all burn sites are taken for culture and sensitivity.

Once the wound has been well-cleansed, topical therapy is initiated to control the number of organisms. Almost all burn wounds become infected to some degree. Most frequently, infections are caused by pseudomonas, staphlococcus aureus, candida albicans and B-hemolytic streptococcus. In the past few years, a number of new topical antimicrobial agents have been introduced. They have in a sense revolutionized burn wound care and have succeeded in reducing the mortality rate of burn patients, especially those with 40-60% body burn. Systemic antibiotics are of relatively little use in the treatment of burn wound sepsis because of the decreased blood supply to the area. However, antibiotics may be given for other infections — pneumonia, urinary tract infections or a full-blown septicemia . Always monitor temperature closely and be alert for complications such as septicemia and septic shock. These can occur anytime. They are a constant threat until healing has taken place.

The choice of an antimicrobial agent depends on the characteristic of the burn wound and on the stage of care (See Drug Chart). Be aware of the untoward symptoms of each drug and be alert for them in your patient.

Dressings

There are three basic types of burn wound dressings:

1. Open or exposure method. This leaves the burn wound open to the air with or without the use of antimicrobial agents. Temperature and humidity in the room are important as well as the maintenance of isolation technique. Partial-thickness wounds dry to form a protective crust while full-thickness burns develop a dry, leathery eschar. These serve to protect the developing granulation tissue underneath.

If topical antimicrobials are used, a thin layer of gauze can be applied for multiple dressing changes. Wounds are cleansed and medication reapplied at least daily.

2. Closed or occlusive dressings. This method is rarely used except for some pre-graft and post-graft stages. These dressings are left on a burn wound for several days, preventing observation by staff and encouraging bacterial growth.

3. Wet dressings. These can be used effectively only if the dressing is kept wet and not allowed to dry out. Dry dressings are placed over the wet dressing.

In all burn wound care it is most important that the wounds be kept clean and that the patient is comfortable. The prevention of contractures essential for the patient's rehabilitation is another area of concern. In relation to this problem, the following areas deserve special mention:

Hands: must be dressed and splinted into a position of function from the very beginning. Burned fingers must be bandaged separately, being sure that no skin surfaces touch. The thumb, whether burned or not, must always be wrapped separately. Since it is harder to correct a contracture than to prevent one, a resting splint should be made on admission (plaster of paris) until one can be obtained from physio or the OT department.

A good splint should do the following:
— exaggerate wrist extension (since this is the first hand function to be lost through immobilization)
— emphasize the web space between the thumb and the hand
— exaggerate flexion of the hand by keeping the fingers straight. If the fingers are not affected, a wrist cock-up splint can be used. It is important that the splint is on the hand snugly but not too tight. Watch for the development of pressure sores. During the early period of a bad burn, the patient's hand should be splinted for 24 hours except for dressing changes.

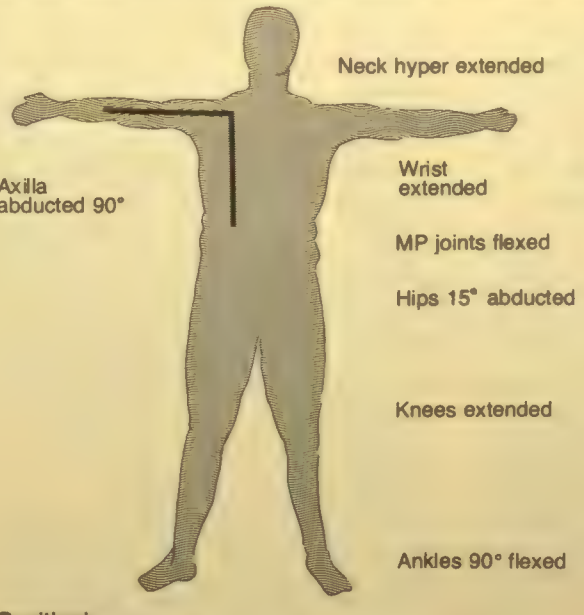
Feet: Again, wrap burned toes separately and place the feet in a resting foot splint.

Knees: If knees are burned, check that they are extended when the patient is in bed. Patients with knee burns tend to develop knee contractures easily.

Hips: In patients with extensive burns that include the groin area, be sure that the hips are abducted approximately 15°.

Neck: Neck contractures develop quickly. A burned neck must be hyperextended preferably in a splint or by the use of a roll under the nape of the neck with no pillow. (See Figure 4).

Figure 4

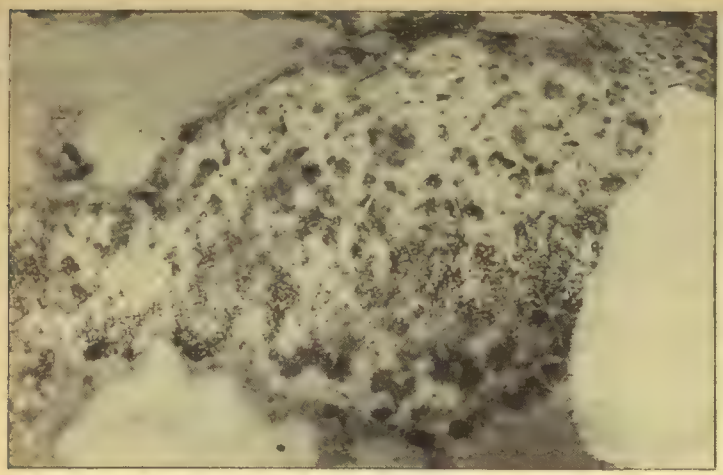


Positioning for the burned patient

Courtesy of Theo van Ulft, Children's Hospital of Eastern Ontario, Ottawa.

Burn Update

Figure 5





Mechanical debridement of the eschar with forceps and scissors.

Debridement

When dressings are changed, the leathery eschar of a full-thickness burn and the slough of a partial-thickness burn need to be removed. Mechanical debridement of this dead tissue can be done with forceps and scissors by the nurse at the bedside or when the patient is in the tub. Only dead tissue that can be cut free without causing excessive bleeding is removed. (See Figure 5).

Patient reactions to the pain of debridement and dressing changes vary. Generally, all patients need an analgesic one-half hour prior to this procedure. Some patients, anticipating that the pain will be severe and feeling that they have no control over the situation, become very tense during debridement. Here are a few suggestions from nurses who work with burn patients at the Montreal General Hospital on how you can help your patient deal with his pain.

- First of all, make a contract with the patient by telling him exactly what you are going to do. Trace out the area that you will debride at this particular dressing change.
- Do not deny his pain. Tell him that you know that it is going to hurt but that it is necessary. Explain that the granulation bed must be clean before it will accept a skin graft.
- Give him some control over the situation by giving him a watch and saying something like "I'm going to debride the eschar for 10 minutes. You tell me when the time is up." Remember to keep your part of the bargain.

Although debridement is not pleasant for the patient, this approach can help in easing his anxiety.

Debridement can also be done surgically in the operating room instead of at the bedside. To prevent excessive blood loss, surgical debridement is usually done soon after admission. Various chemical enzymatic debriding agents are being used in some centers in Canada. One such agent, Travase, selectively digests necrotic tissue by a proteolytic action. Those who favor its use say that it hastens the formation of granulation tissue and wound healing. Others against its use feel that its side effects outweigh its value (See Drug Chart). When it is used, an antimicrobial agent is also used.

Grafting

As we have seen, the ability of a burn wound to heal and to produce new skin is directly dependent on the depth of burn damage. In full-thickness burns, grafting is necessary for wound closure and should be done as soon as possible to minimize infection and loss of function. Grafting is often done in partial-thickness burns as well, to provide more durable skin coverage and better function.

The source for a permanent skin graft is the patient's own skin, called an *autograft.* This skin can be taken from any area of the body that is intact. If there is no available skin for grafting, as in cases of large burns, temporary grafts are used until the patient's own skin is available. These temporary grafts can be *homografts* — skin histiologically compatible with the patient's and obtained from family members or human cadavers or *heterografts* — skin coverings from animal sources such as bovine, canine and porcine tissue or those from synthetic materials such as Teflon, and nylon-velour. These temporary grafts serve to prevent evaporative water-loss by acting as semi-permeable membranes and to reduce the pain of healing.

There are two basic types of skin grafts:
1) split-thickness grafts which tend to take better than a thicker graft and are most frequently used in the initial management phase, and
2) full-thickness grafts which produce a good cosmetic appearance and are used more commonly during later treatment.

When the granulation bed (burn wound area) is clean, free from infection and has developed a good blood supply, the area is ready to be grafted provided that the patient's condition is stable and he is in a good nutritional state. The donor site can be prepped as in any operative procedure or this may be done in the operating room. Skin is harvested from the donor site with a dermatome. An occlusive dressing such as "Scarlet Red" can be applied to the donor site and left on for 7-10 days or the site can be left open. With good care, donor sites heal within 10 days to two weeks and can be used many times. In the case of full-thickness grafts, the donor sites will themselves require a split-thickness skin graft to heal.

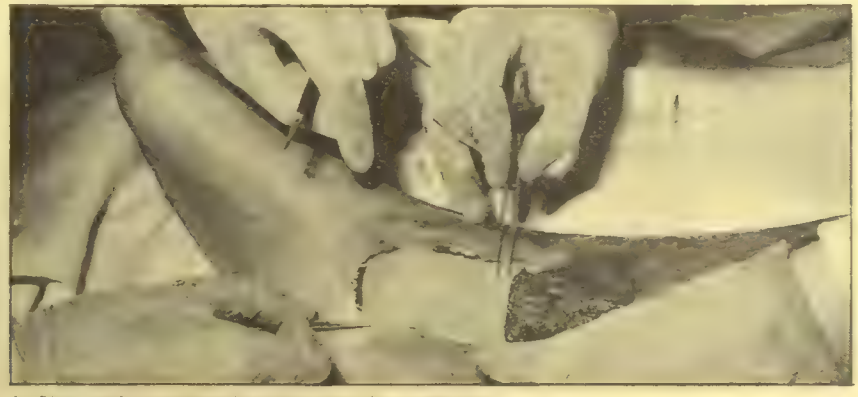
Skin grafts may be applied in the OR or in the patient's room. Dislodgement is the most critical problem in the care of a skin graft. Some hospitals have found that there is an increased possibility of dislodgement during the patient's trip back to his room after surgery and in his transfer from the stretcher to his bed. At the Montreal General Hospital, skin grafts are applied by the staff nurses on the patient's return from the OR. (See Figure 6).

Graft sites can be left exposed or covered with a wet or dry dressing. The exposure method allows for close observation of how well the graft is taking. With the exposure method however, the patient may need to be immobilized with splints, slings or traction to prevent dislodgement. If occlusive dressings are applied, these are removed only on specific order. A graft that is taking well will appear pinkish-red and adhere smoothly to the granulation bed. A graft that appears white or darker than the original tissue indicates that the graft is not taking.

Figure 6



1. A leg ulcer that is ready for grafting.



2. Skin graft positioned on the ulcer bed with the shiny side down.



3. Trimming the skin graft for an exact fit.



4. Skin graft in place.



5. Application of Steri-strips* to hold the graft in place.

* Steri-strips is a registered trademark of the 3M Company.

Burn Update

Emotional reactions

The person who suffers a severe burn will need help and understanding to cope with the tremendous problems he will have to face. He will have to deal with disfigurement, possible disability, unemployment, separation from family, and perhaps loss of family members. He will have to cope with a long period of hospitalization and all that it entails — tubbings, exercises, debridement, grafting and chronic pain. Although all illnesses seem to involve some expression of anxiety, regression and depression, these reactions are often markedly exaggerated in the burn patient. Painful treatments on a long-term basis tax his emotional resources and can accentuate any psychological problems he may already have. Pain can also distort his sense of reality.

His relationship to the nursing staff is often a love-hate relationship. No other aspect of nursing requires the staff to inflict so much pain in patients in the course of necessary treatment. Obviously, this causes ambivalent feelings in both the patient and the nurse. The patient knows that the procedures are necessary and realizes that the nurse is helping him improve, but at the same time, he sees her as the cause of his pain and may express his anger in verbal abuse towards her. Staff's reactions to this kind of behavior can vary. Some nurses may feel that their nursing skills are inadequate, that they should not be causing so much pain. Others may mirror the patient's emotion and become angry themselves. Often, manifestations of this anger can be seen when nurses withhold pain medication or label the patient as a "baby" or "difficult." In dealing with this situation, it is important that staff nurses objectively analyze the reasons why the patient acts in a certain way and then try to find ways of helping him cope with all the things that are going on. Staff meetings and consultations with psychiatry are ways that can be used by the staff to ventilate their own feelings and to discuss approaches that might be used.

Families of burn patients also experience intense emotions and need a great deal of support to cope with their feelings. One of the most effective means for the staff to provide this support is to teach the family about the situation. They need to know what is happening to the patient and what to expect. Knowing that the patient is receiving good care does a great deal to alleviate their anxiety. Effective and thorough teaching for the family takes not only time and planning but also a sense of caring on the part of the nursing staff.

Nursing the burn patient is not an easy job. It demands specialized knowledge, good technical and observational skills and insight into human behavior. The quality of nursing care the burn patient receives will in large part determine the extent to which he will heal physically and adjust emotionally to this crisis.

DRUG CHART

ANTI-BACTERIAL

SULFAMYLON 10%

Generic Name
Mefenide

Indications
- a topical anti-bacterial agent used for 2° and 3° burns.
- diffuses through avascular burn tissue to control infection.

Effectiveness
- effective against many gram-negative and gram-positive organisms including some anaerobes
- helps prevent partial - thickness wounds from converting to full-thickness wounds because of infection.
- helps prevent bacterial invasion of unburned tissue.

Precautions
- safe use has not been established during pregnancy.
- fungal colonization in and below eschar may occur.

Side Effects
- pain or burning sensation on application is common.
- allergic manifestations such as rash, itching, facial edema, swelling, hives, erythema.
- respiratory problems e.g. tachypnea, hyperpnea, hyperventilation due to acidosis. Sulfamylon inhibits carbonic anhydrase which in turn causes ↑ excretion of sodium bicarbonate leading to metabolic acidosis.

Application
- apply directly to burn wound surface using a sterile tongue blade, sterile gauze or by sterile gloved hand.
- apply enough cream so that the burn wound is not visible.
- may be left on the wound uncovered or, it can be covered with fine mesh gauze. May also be used in occlusive dressing.
- usually applied twice daily and as necessary.

Nursing Considerations
- cleanse wounds thoroughly before new application e.g. tubbing is the best way to remove cream or soak with 1/2 warm normal saline and 1/2 hydrogen peroxide to facilitate easy removal.
- sedate 20 minutes before dressing change due to stinging sensation on application.
- eschar takes longer to slough because eschar separation is dependent on the proteolytic action of bacteria.

ANTI-MICROBIAL

FLAMAZINE, SILVADENE

Generic Name
1% Silver Sulfadiazine Cream

Indications
- a topical anti-microbial agent for adjunctive treatment and prevention of infection in severe burns.

Effectiveness
- best results obtained if applied as soon as possible on a burn wound that is well cleansed to prevent subsurface bacterial penetration.
- effective against gram-negative, gram-positive organisms as well as candida albicans.

Precautions
- caution with hepatic or renal impairment. Kernicterus may develop.
- fungal colonization in and below eschar may develop.

Interaction
- if used in conjunction with a topical enzyme, the silver may inactivate such enzymes e.g. travase.

Contraindications
- sulfonamide sensitivity.
- do not use during pregnancy or with newborn infants.

Side Effects
- although flamazine is painless, such reactions as burning, rash, itching, and one case of interstitial nephritis have been reported.
- toxic reactions associated with sulfonamides.

Application
- apply topically 2-4 mm thickness with sterile gloved hand or sterile tongue blade.
- store in a cool place away from the light.
- wound may be left exposed or an occlusive dressing may be used.

Nursing Considerations
- cleanse wounds thoroughly before new application. This agent has a tendency to form a crust if not removed at time of dressing change.
- check carefully for signs of purulent accumulation in subeschar space and remove.
- dressings may have a slimy, greenish-gray appearance but this is not necessarily indicative of gross infection. Check cultures and clinical status of patient.

BACTERIOCIDAL AND FUNGICIDAL

BETADINE OINTMENT AND 10% SOLUTION

Generic Name
Providone-Iodine N.F.

Indications
- a topical bacteriocidal ointment that can be used in conjunction with betadine 10% solution during all phases of burn wound care to prevent sepsis.

Effectiveness
- effective against a wide variety of gram-negative and gram-positive organisms, fungi, yeasts, protozoa and viruses.
- most effective for a 6-hour period after application.

Contraindications
- iodine allergies.

Side Effects
- allergy reactions such as irritation, redness, swelling.
- possibility of T3 and T4 elevation. Iodine levels will return to normal after cessation of therapy.

Application
- apply ointment with sterile gloved hand or sterile tongue blade so that burn wound is completely covered.
- ointment is applied twice daily at dressing changes. At 6-hour intervals between dressing changes, wet the dressing with betadine solution.
- can also be used over fresh skin grafts or on areas that are clean and healing.
- useful for the treatment of burned ears. Apply q8h.

Nursing Considerations
- give pain medication 20 minutes before dressing change.
- stinging or burning associated with application is of relatively short duration.
- betadine has a tendency to build up a crust, therefore, cleanse areas well e.g. tubbing, shower or bedbath.
- debride loose tissue, then apply ointment.
- check for side effects.
- tendency to stain material.

BACTERIOCIDAL

SILVER NITRATE 0.5% SOLUTION

Generic Name
Silver Nitrate

Indications
- a bacteriocidal agent used for continuous wet dressings on burn wounds and over skin grafts.

Effectiveness
- penetrates only 1 to 2 mm of burn eschar, therefore, controls only surface bacteria on the wound.
- treatment must be initiated early before deep colonization of the wound develops.

Interaction
- if used in conjunction with a topical enzyme, the silver may inactivate such enzymes, e.g. travase.

Side Effects
- depletion of serum potassium and sodium levels.

Application
- use 6-8 layers of 4-ply gauze dressings, all thoroughly wet with silver nitrate solution.
- debridement done at time of dressing change.
- dressings must be kept wet with silver nitrate solution at all times between dressing changes. If dressing becomes dry, concentrated solution can cause damage to underlying tissue.

Nursing Considerations
- amount of time spent on dressing changes and staining are problems.
- warm, soapy water helps remove some stains from skin. Tubbing helps.
- keep patient warm. Body heat is lost through evaporation.
- once eschar is removed, exposed areas of deep, partial-thickness burns will be painful during dressing changes. Give sedation.
- essential that patient receives supplemental calcium, potassium and sodium.

ENZYMATIC DEBRIDING AGENT

TRAVASE

Generic Name
Sutilains Ointment N.F.

Indications
- a topical enzymatic agent used to dissolve and remove necrotic tissue in 2° and 3° burns.

Effectiveness
- selectively digests necrotic soft tissue by proteolytic action and facilitates removal of burn eschar and purulent exudate to hasten formation of granulation tissue and hasten wound healing.
- appears to have no effect on normal tissue.
- treatment starts either immediately or 3 days post-burn and continues for 5-7 days.
- optimal activity level at body temperature with a pH of 6.0 - 6.8.
- effectiveness seen within 24-48 hours.

Precautions
- do not allow enzyme to come in contact with eyes. Flush eyes with copious amounts of water if this occurs.
- do not use on more than 15% of body surface at a time.

Interaction
- enzyme may be rendered inactive if applied in conjunction with certain detergents and antiseptics e.g. silver nitrate, flamazine. However, sulfamylon and flamazine are often used concurrently with travase with apparent success.

Contraindications
- not to be applied if wounds communicate with major body cavities or near exposed major nerves or nerve tissue.
- pregnancy.

Side Effects
- mild, transient pain probably due to friction on nerve endings.
- paresthesia.
- bleeding.
- transient dermatitis.

Application
- apply agent with a sterile gloved hand as a thin layer making sure to go into the crevices of the wound and to overlap 1/4 inch of skin all around the wound.
- apply wet dressing of sterile water or normal saline over the ointment. THE DRESSING MUST BE KEPT MOIST AT ALL TIMES FOR THE ENZYMATIC ACTION TO OCCUR.
- apply travase 1-4 times daily as ordered.
- if wounds are infected, a layer of topical anti-microbial can be used over the travase. Wet dressings are applied as usual.

Nursing considerations
- refrigerate travase to maintain potency.
- clean wound area well and keep area moist e.g. tubbing, shower or wet soaks before application.
- give medication at least 20 minutes before procedure.
- wet the dressings prn to keep moist.
- observe patient for clinical signs of sepsis.
- observe patient for dermatitis or unusual bleeding. Discontinue drug.

Acknowledgement: *I would like to thank the nursing administration department of the Montreal General Hospital for their help in the initial planning of this article. Special thanks go to the staff of 5 West, Protective Isolation Unit, and to the physiotherapy, dietetics, occupational therapy, infection control, psychiatry and photography departments at the Montreal General for their cooperation and assistance in the research and writing of this article. Their help during my visit, particularly the help and support of Anne Dickson, head nurse, Jutta Yegavian, staff nurse, and Susanna Jack, psychiatric nurse consultant, is greatly appreciated. Lastly, I would like to express my gratitude to the burn patients on 5 West for their help and cooperation during my visit.* — **S.L.**

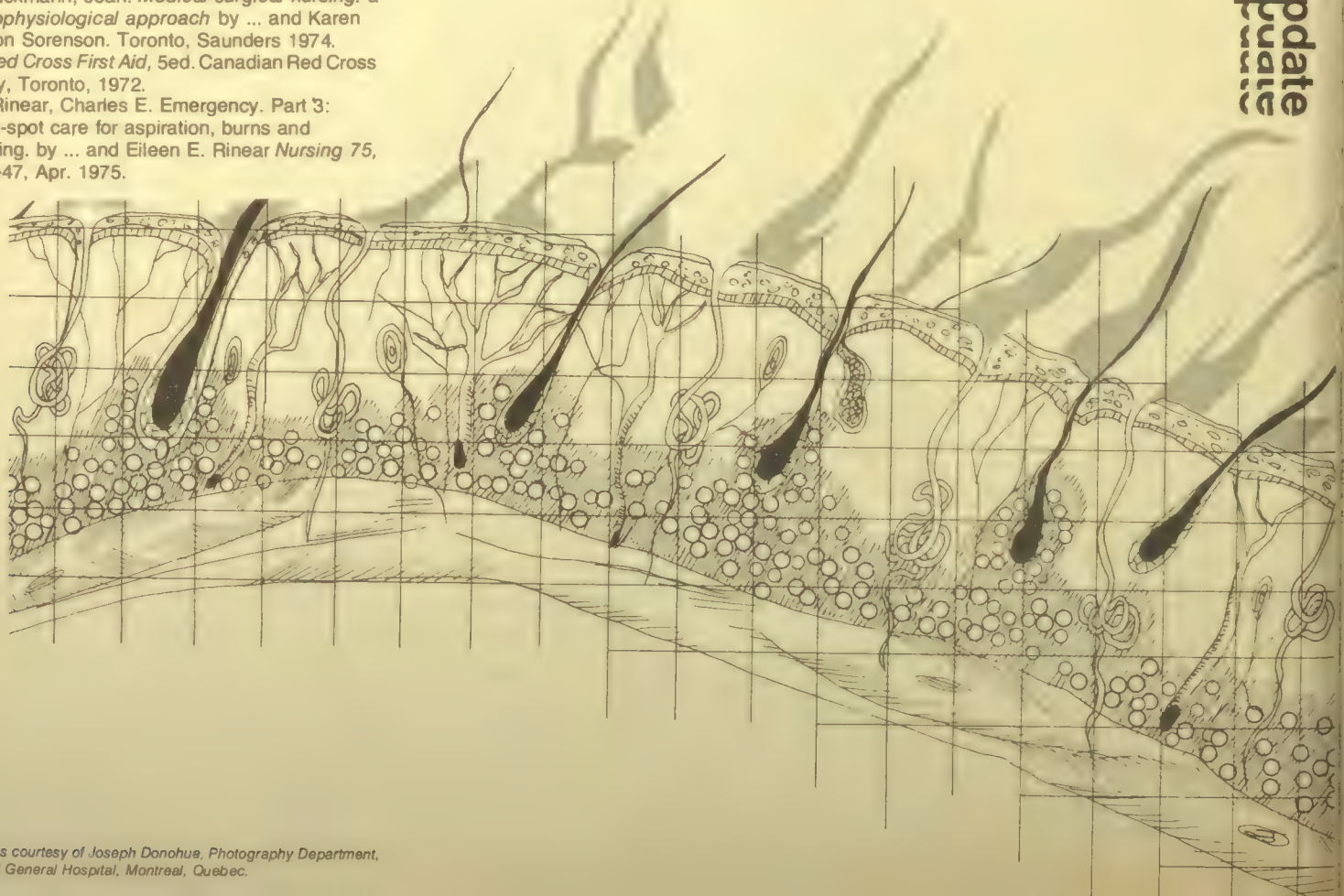


Some of the nursing staff from 5 West, Protective Isolation Unit, Montreal General Hospital who assisted in the preparation of this article: From left to right: Back row: Juliette Burke, Cathy Knowles, Donna Marshall, Martha Turnball. Front row: Zenida Ramos, Wendy Ward, Anne Dickson, Perely Spence.

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Burn Update



All photos courtesy of Joseph Donohue, Photography Department, Montreal General Hospital, Montreal, Quebec.

Clinical Wordsearch no. 8

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has five words. (Answers page 31).

S E P R N K S E R U T C A R T N O C
T I L W T N F F S S H S S H H H S B
F S L C T A R I H I I H S O E T L U
A O D V I T E R Y S M O O T F I A R
R L E C E D E E P O U C L A S N L N
G A B H S R E E O R I K R T O P L S
O T R E G A S P V C D G E I L N O I
T I I M N B C U O E O R T A I M G L
U O D I I B I E L N S I S A S R R V
A N E C S U T E E F N M P F H C A E
P S M A S H P X M G A M E D E O F R
R C E L E S E S I R R D E E A R T N
O A N S R K S U A E R O I E R R E I
T L T K D I A N E D I N E A T O K T
E D G R A N U L A T I O N O Z S A R
I N O I T C E F N I R R A C S I T A
N S S E N K C I H T T I L P S V N T
H Y P O N A T R E M I A R I A E I E

1 Robert or George *(5)*
2 Type of tissue formed when soft tissue wounds heal. *(11)*
3 Decreased amount of circulating fluid in the body. *(11)*
4 May result from being too close to the flame, or new shoes. *(8)*
5 Excess of fluid in intercellular spaces. *(5)*
6 The temperature that must be reached in order for a substance to burst into flame. *(8)*
7 What's burning in a Class "B" fire. *(8)*
8 The effect of a strong alkali. *(9)*
9 Too little blood or too much electricity causes this state. *(5)*
10 Necessary to make cauldrons bubble. *(4)*
11 Includes both oral and parenteral fluids. *(6)*
12 Removal of foreign material and devitalized tissues. *(11)*
13 Pertaining to the absence of disease-causing microorganisms. *(7)*
14 $AgNO^3$ *(6, 7)*
15 A graft of skin in which three sides are freed from donor site and fourth remains attached to maintain blood supply. *(7)*
16 Deficiency of sodium in the blood. *(12)*
17 An odorless cream applied to burns which does not precipitate Cl as readily as $AgNO^3$ and has the antibacterial action of sulfonamides. *(6, 12)*
18 Caused by the invasion of pathogenic organisms. *(9)*
19 Special tub for bathing burn patients. *(7, 4)*
20 Death of a cell or group of cells. *(8)*
21 Deformities which may result from healing of third degree burns. *(12)*
22 A graft taken from the patient's own skin. *(10)*
23 Graft not attached to donor site. *(4)*
24 A morbid condition resulting from the presence of pathogenic bacteria and their products. *(6)*
25 Skin transplant from a person other than burn victim. *(9)*
26 Segment of skin taken from an animal such as a pig or a dog. *(10)*
27 Render burns occlusive. *(9)*
28 Food substance necessary for building new cells and tissue. *(7)*
29 Source of blood or transplants. *(5)*
30 The chief cation of extracellular body fluids. *(6)*
31 What is decreased in #3. *(6)*
32 There's none off my back. *(4)*
33 This burn is relieved by antacids. *(5)*
34 Often necessary as a protective measure for badly burned patients. *(9)*
35 There is usually a —— of body fluids in burn victims. *(4)*
36 Often results from upset saucepans. *(5)*
37 Cause of ultra-violet burns. *(3)*
38 What's left of last year's burn. *(4)*
39 Sometimes felt more with 1st degree than 3rd degree burns. *(4)*
40 "Warm to touch" — as we say in the profession. *(3)*
41 Appearance of burn of #37. *(3)*
42 One factor used in assessing the severity of a burn. *(3)*
43 As necessary. *(3)*
44 A graft of skin between 0.010 — 0.035 inches. *(5, 9)*

Coping with pain:

Strategies of severely burned children

Marilyn Savedra

For the severely burned child awareness of pain soon becomes all encompassing. Because no previous experience he has had could in any way prepare him to understand what is happening, he "exists in a state of confusion, fear, panic and hurt."[1] Pain may not only be present as the child lies quietly in bed, but accompanies almost every move he makes, every nursing measure utilized in his care, and every therapy ordered by the physician. It is weeks and months before helping no longer involves hurting. Anxiety resulting from the traumatic situation and communicated by concerned parents may enormously increase the pain. Pain relieving medication is limited for the child must be alert enough to cooperate with treatments and to maintain adequate food and fluid intake.[2]

Nurses and others responsible for the care of the burned child are constantly involved in procedures which inflict pain, attempting to get the child to cooperate in pain producing experiences, and coping with the child's response to pain. While nurses who work with such children expect to cause pain and to experience outbursts from the child they are often unprepared for the intensity and duration of the child's response.[3]

The question was asked, how does a child cope with the intense, seemingly never ending pain of an extensive burn? The answer came from observation of five children hospitalized with severe burns. Observations were made several times a week at varying times of the day and evening during the major portion of the hospitalization.

Coping

As defined by Lazarus[4] coping refers to strategies for dealing with threat. When threat is perceived the child's actions are directed toward reducing the anticipated harm the threat engenders. Murphy[5] suggests: "When a situation involves some threat, the child's action in relation to the threat may move in any one of several different directions; he may attempt to reduce the threat, postpone, bypass it, create distance between himself and the threat, divide his attention, and the like. He may attempt to control it by setting limits, or by changing or transforming the situation. He might even try to eliminate or destroy the threat. Or he may balance the threat with the security measures, changing the relation of himself to the threat or to the environment which contains it, but which also includes sources or reassurance."

The Children

The children studied ranged in age from 6.0 years to 9.5 years. All burns were primarily second and/or third degree and covered 30 percent to 65 percent of body surface area. In all cases the child's clothing had caught fire. (See Table 1). Of the five, Sherri alone did not survive, dying nine and one half weeks postburn as the result of infection. One of the children (Jane) was hospitalized in a private room of a children's hospital. The other four received care on a burn unit and for the major portion of their stay were together in a six-bed ward.

The Pain

The most intense pain occurred with the direct care of the burn wound.[6,7] Regardless of the therapy, all of the children responded, particularly during the first weeks, with hysterical screaming while their burns were being dressed. As grafting proceeded the pain from the burn wound decreased but the donor site became an additional source of pain.

As time progressed, some children became less tolerant of the pain. Fifty-two days postburn Jane screamed with greater forcefulness than had been previously observed. She said it hurt more. It was 85 days postburn that Larry screamed during his dressing change that he wanted to die. He kept repeating "Oh God, I love you," and cried for God to heal his skin.

Sherri associated screaming with pain and burns. Once when she heard someone scream on a television show in another part of the ward, she asked if I thought someone was being burned and if the house was on fire. I asked if she had screamed when she had been burned. She replied that she had, a little, because it hurt.

Strategies for Coping

Several strategies for coping with pain emerged from the data. Categorization in part was based on the work of Murphy[5].

Reduction of Threat

Reduction of threat was a strategy used consistently by two of the children. Pain was anticipated and efforts were made to lessen the expected pain.

My introduction to Jane came at the time of a dressing change. Her nurse was removing dried Sulfamylon with saline soaked gauze. Jane was lying in bed naked, trembling, with face drawn, hitting the bed with her foot. Between her piercing screams, she pleaded, "Don't hurt me Connie, I don't want you to hurt me. Do it lightly." During painful procedures she would repeat over and over, "Don't hurt me."

Sherri, too, used reduction of threat as a strategy. At the time of tubbing and dressing change she pleaded with nurses, "Go easy. Go very, *very* easy."

Postponement

Postponement was a frequently used strategy. Jane regularly stated a need to sleep or rest when tubbing and/or dressing changes were announced. When Sulfamylon was removed by hand she pleaded to be allowed "to dry" before more was applied. She also insisted at times that she had to go to the bathroom just as she was to go into the tub. On one occasion her mother participated in Jane's postponing strategy by counting to 25 before the treatment was allowed to begin.

Jennifer was heard pleading with her nurse not to be the first person to be put into the tub. Sherri once wanted to wait six weeks before having her dressing changed. Larry tried to postpone pain producing situations by asking if nurses were acting on doctor's orders.

Bypass

An attempt to bypass a procedure was a strategy used less frequently than postponement. Jane once asked her nurse to "just pretend" to do the dressing change. When told this was not possible she said she wished to die. Asked why, she replied that she did not want to be hurt. Once Jane asked if I thought she would have to have a bath if she prayed to God. When asked what she thought she replied that she would have the bath because people were praying that she would get well.

Jane, Sherri, and Larry most often used the bypass strategy when routine care, including position change, was to be carried out. Sherri once said she did not need to go into the tub. She reasoned that she did not have a bath every day at home.

Creating Distance Between Self and Threat

Immobility of all of the children during a major portion of their hospitalization made creating distance between self and threat an impossible strategy to be used.

Larry, toward the end of his hospitalization, made an attempt to utilize it.

Burn Update

When told that his dressing needed to be changed, he screamed that he did not want it done because it hurt. He asked me to remove his covers and pillows so he could get out of bed. Jane on two occasions, involving a dressing change attempted to keep her nurse at a distance by kicking her legs.

Dividing Attention

Kenny most effectively used the strategy of dividing his attention when experiencing pain from needles. He wanted me to hold his hand and tell him what to talk about during the procedure. My suggested topic was readily accepted. Once he started talking and then stopped to check with the nurse giving the injection to see if it was the right time for him to talk.

Jennifer also asked me to hold her hand during a dressing change. She still screamed throughout the procedure but became smiling and cheerful when it was completed. She thanked me for holding her hand stating her mother usually did so at such times.

Nurses attempted to get children to use this strategy. Larry was urged to talk to me while in the tub. He ignored the suggestion. Jane screamed only intermittently during a tubbing when a nurse read a story to her. She appeared to listen. However, when I asked her if she had listened to a story when she was in the tub she said she hadn't because she was too busy screaming.

Sleep

Withdrawal into sleep was a behavior frequently used by Jane but used less frequently by the children on the burn unit. It was not always possible to determine when sleep was a result of physical need or was used to avoid a painful situation. Jane did use sleep as a coping strategy. Once she told me that if she was asleep she would not have to have a shot. A nurse commented that when Jane thought something would hurt she would say she needed sleep. After surgery Jane used sleep at least partially as a retreat.

Jennifer, when first admitted to the burn unit, spent much time sleeping. Kenny, throughout his hospitalization, spent considerably more time during the day sleeping than did Sherri or Larry.

Sherri did associate sleep with absence of pain. Anesthesia was given at times prior to the tubbing which preceded surgery. She, and other children on the unit, would beg to be asleep when they went into the tub so it would not hurt.

Table 1

Data on Children

Names	Age (years) at time of accident	Body surface area burned	Severity	Length of hospitalization
Jane	7.10	45%	Primarily 3rd degree	114 days
Larry	9.5	62%	Primarily 3rd degree	118 days
Sherri	6.0	65%-75%	Primarily 3rd degree	73 days deceased
Kenny	7.9	30%	Primarily 3rd degree	47 days
Jennifer	8.9	32%	2nd and 3rd degree	44 days

Responses to Crying of Others

For the severely burned child crying and/or crying out appears to be associated with pain and discomfort. It is distressing to the child and he therefore attempts to control this behavior in others as a mechanism for coping with his own situation.[8]

Jane and Larry were both intolerant of other children crying. Jane while listening to a child across the hall stated there was no reason for him to cry like that. She had not cried that hard, she said, when she was burned. When Jennifer moaned and groaned, Larry suggested she be put in the tub room. When Sherri was moved from the ward to a semi-private room shortly before her death, Larry told me the move had been made because Sherri cried and disturbed people.

Discussion

All five of the children studied could be classified as active copers.[9] Patterns of coping could be identified for individual children. While each was severely restricted in many ways each made definite efforts to control the environment. Because of the immobility imposed for much of the hospitalization the coping style of each was essentially verbal in nature. The age of the children made this possible.

It would appear from this limited sample that postponement was frequently attempted and was more common than attempting to bypass the pain producing situation. Strategies to reduce threat were also common while devices to divert attention were infrequently used. Creating distance between self and the threat was not physically possible for the severely burned child.

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Nutrition and the burn patient

Providing adequate fluids and a nutritious diet high in calories and protein is one of the most important aspects in the treatment of the burn patient. Satisfactory wound healing and successful skin grafting are dependent on the patient's optimal nutritional state. Here, a dietician discusses the nutritional management of the burn patient and some aspects of diet planning.

Rosemarie Repa Fortier

Nutritional needs of the burn patient

Hypermetabolism and hypercatabolism, two states which characterize the body's response to a burn injury, result in an increase in energy and protein requirements.[1] One source states that the basal metabolic rate of a burn patient may be increased as much as 40-50% greater than normal.[2] To meet these increased energy requirements, the burn patient needs a diet high in calories.

High caloric intake is also necessary to minimize or prevent weight loss during the post-burn period. The weight loss of a severely burned patient during hospitalization may be from 25% to 33% of his pre-burn weight, depending on the percentage of body burn.[3] The greater the burn, the greater the weight loss.

The ideal caloric intake is determined by the following equations proposed by Pennisi:

Adult (20 kcals x kg body weight) + (70 kcals x %burn).
Child (60 kcals x kg body weight) + (35 kcals x %burn).

Once the calorie requirement has been calculated, the protein requirement is calculated as follows:

Adult (1 gm x kg body weight) + (3 gm x % burn).
Child (3 gm x kg body weight) + (1 gm x % burn).[4]

Initially, the protein requirements of the burn patient are increased due to the loss of body weight and to the great amount of nitrogen lost during catabolism (the breakdown of tissue). **High protein intake** is necessary throughout the convalescent period due to the continued loss of nitrogen from the burn wounds.[5] A low serum protein resulting either from secondary infection to the burn site or low dietary intake of protein rich foods may decrease the rate of wound healing.[6]

Polyunsaturated fat is necessary in the diet to prevent essential fatty acid deficiency, which may occur during the catabolic phase.[7] Fats supply a concentrated source of energy and are important sources of fat-soluble vitamins. Carbohydrates supplying energy, provide the remaining necessary calories in the diet. Fat and carbohydrate must be present in adequate amounts to be used as energy in order to prevent the channeling of too much protein for this purpose. This "protein-sparing action" of carbohydrate allows a major portion of protein to be used for its basic structural purpose of tissue building.

Other nutrient requirements must also be considered in the nutrition of a thermally injured patient. **Multivitamins** should be administered daily. An increased ascorbic acid level is necessary to provide collagen synthesis and promote capillary strength. Vitamin A requirements are increased to maintain healthy epithelial cells, which form the body's primary barrier to infections. A suggested dosage is 500 mg of ascorbic acid q.i.d. and 50,000 units of vitamin A b.i.d.[8] In addition, others suggest 50 mg of thiamin, 50 mg of riboflavin, 500 mg of niacinimide and 600 mg of zinc sulphate.[9] Iron rich foods should also be stressed, as hemoglobin levels often decrease following burn injury. An iron supplement is often necessary.

Serum potassium is excreted in large quantities during the early stages of thermal injury. A 400 mEq supplement of **potassium** is recommended per day, to maintain normal serum concentrations.[10] Potassium depletion should be closely watched in cardiac patients and in the elderly.

A **high fluid intake** is necessary to compensate for fluid losses through evaporation. A severely burned patient may lose between 2.5 and 4.0 litres of fluid in evaporation daily.[11] High protein, high calorie drinks can also be given.

Considerations in meal planning

Until resolution of post-traumatic or paralytic ileus, the severely burned patient will remain on I.V. fluids. Clear fluids are usually administered three to four days post-burn. The progression from full fluids to a full, high-protein, high-calorie, high-fluid diet follows as soon as the patient is able to tolerate solid foods.

A nutritional history, illustrating food preferences, should be completed with each patient. Diabetes, cardiac, renal or liver illnesses must be considered when the patient's menu is prepared. Meals should be presented attractively, considering contrast in color and texture, as well as providing a good variety in foods. A pattern of three meals supplemented by high-protein, high-calorie nourishments between meals is established. Milk or milk nourishments, such as milkshakes, eggnogs, vitaminized juices or commercial high-protein liquid supplements can be offered. Nourishments require regular variation due to the long-term hospitalization of these patients. They are essential in the early post-burn stages when the patient's appetite is poor.

Soft foods are advantageous during the initial periods of hospitalization as they are more easily digested. For patients with face and neck burns, or burns around the mouth, it may be necessary to offer pureed or minced foods. A patient who has sustained severe burns to arms, hands or fingers should be

given foods in a form that can be easily eaten. Foods which are cut up or soft will eliminate unnecessary effort. All patients should be encouraged to feed themselves to help overcome their feelings of helplessness. A great deal of support is needed to overcome the frustration or discouragement which a patient may have in trying to eat his meals.

Good nutrition must be emphasized by the health team throughout the convalescent stages. Despite the patient's depression and anorexia, his life may depend upon rigorous nutritional therapy. The high-protein, high-calorie, high-fluid diet continues until separation of the eschar and the grafting of the burn wounds is complete.

Evaluation of nutritional management

Daily caloric intakes, showing the protein, fat and carbohydrate intake, are required to evaluate the success of the diet therapy. The patient's weight should be recorded routinely, at least twice a week. For greater accuracy, the patient should be weighed at the same time each day (preferably before breakfast) and after the removal of wound dressings.

Establishing a weight loss of 10% body weight as a limit is an important guideline for the nutritional care of individuals with thermal injury.[12] However, this limit may not be possible in patients with greater than 40% total body burns. If the patient reaches a 10% weight loss and his food intake is insufficient to meet his caloric needs, an alternate feeding method will have to be prescribed. A tube feeding or hyperalimentation may be used as a supplement or alternate feeding method. Tube feedings should be discontinued as soon as possible due to the danger of respiratory infection, aspiration and gastric dilation.[13] Central venous hyperalimentation may also cause complications such as sepsis and metabolic complications and therefore should be used only with extreme care.[14]

In summary, optimal nutrition is extremely important for a patient who is burned, to prevent negative nitrogen balance, to minimize weight loss, to provide for adequate wound healing and skin grafting and in the case of children, to continue normal growth and development. The nutritional management of burn patients requires the involvement of the health team — physicians, nurses, psychologist, occupational therapist, social worker and dietician — to achieve good results.

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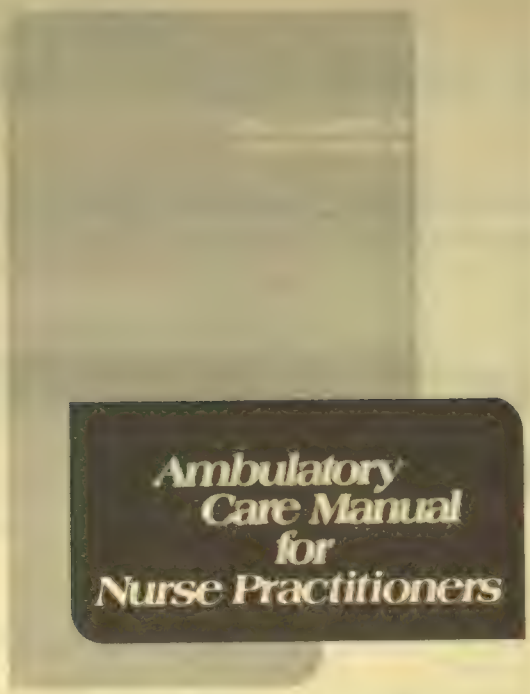
Clinical Wordsearch

Answers

Puzzle no. 8 (appears on page 27)

1 Burns
2 Granulation
3 Hypovolemia
4 Blisters
5 Edema
6 Ignition
7 Chemical
8 Corrosive
9 Shock
10 Fire
11 Intake
12 Debridement
13 Aseptic
14 Silver Nitrate
15 Pedicle
16 Hyponatremia
17 Silver Sulfadiazine
18 Infection
19 Hubbard Tank
20 Necrosis
21 Contractures
22 Autografts
23 Free
24 Sepsis
25 Allograft
26 Xenografts
27 Dressings
28 Protein
29 Donor
30 Sodium
31 Plasma
32 Skin
33 Heart
34 Isolation
35 Loss
36 Scald
37 Sun
38 Scar
39 Pain
40 Hot
41 Red
42 Age
43 P.R.N.
44 Split thickness

Hidden Answer: Where there's smoke there's fire.



(1) AMBULATORY CARE MANUAL FOR NURSE PRACTITIONERS

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The International Grenfell Association

In 1891 a young English doctor, Wilfred T. Grenfell, travelled to Labrador and was appalled at the living conditions he saw there. The people of Labrador, isolated by geography and climate, suffered malnutrition, tuberculosis, a general lack of any medical care and a serious lack of schooling for their children.

This visit prompted Grenfell's return to Newfoundland the next year. This time he came with staff and supplies, prepared to stay and give medical care to the Eskimo and white families living in the isolated communities along the coast.

Remarkably the Grenfell International Association has had only three chiefs in its eighty-five year history: the founder, Sir Wilfred Grenfell from England; his successor, Dr. Charles Curtis from the United States; and the Association's current leader, Dr. Gordon Thomas who is Canadian.

Gordon Thomas first went to northern Newfoundland in 1946. At that time there were only four full-time doctors on the coast and only twenty-five nurses for four hospitals and five nursing stations. Communication was still carried out through Gerald S. Doyle radio news bulletins. Travel was still by foot during the spring break-up season, by schooner in the summer and by dog-team in the winter.

Today, the International Grenfell Association operates on a budget of over $13,000,000 with a staff of more than 800 employees including some 150 nurses. Through its fifteen nursing stations, four hospitals and a community health center the

Outpost Nursing in Northern Newfoundland



The medical care of the people in northern Newfoundland and Labrador is administered by the International Grenfell Association. Primary health care is provided by nurses located at Grenfell Association nursing stations. One such station is located in Cartwright, Labrador, a town of 600, and it was here that co-authors Jane Graydon and Judith Hendry carried out their investigation into the special skills and knowledge demanded of nurse practitioners practicing in remote areas of this country.

Jane Graydon
Judith Hendry

There are usually two nurses at the Cartwright nursing station. For one month each last summer both Jane and I acted as the second nurse in this setting. We went to Cartwright to become more familiar with the knowledge and skills required of the nurse practitioner and to gain some experience in this expanded role ourselves.

Cartwright's population falls to about three hundred in the summer because most of the townspeople leave to spend this time fishing in smaller communities along the coast. Although we were there during the summer we believe the situation described here does illustrate that which exists at other times in the year.

The Nursing Station at Cartwright

Cartwright's nursing station is made up of a clinic, a treatment room, in-patient facilities for seven adults and three children, a delivery room and living accommodations for the nurses. There is a telephone and a radio transmitter for communication with the 'outside' world.

Each morning a physician in North West River, Labrador attempts to contact the station

Association serves approximately 50,000 people. The Association has moved into the jet age using Air Ambulances to transport patients to hospitals rather than bringing hospital ships to them.

The hospitals and medical work of the Association are now financed almost entirely by government sources. The government of Newfoundland also provides the aircraft vital to the modern health care program.

Health care work is centered at St. Anthony, Labrador. The hospital here maintains a Grade A accreditation with an organized medical and nursing staff. It is affiliated with Memorial University Medical School and the Dalhousie University School of Outpost Nursing. This summer the Grenfell Association has employed students from the Memorial University School of Nursing as summer vacation relief.

The Grenfell International Association provides a complex system of health care in a frontier area. Their system is based on the principle of multiple nursing stations that refer to regional hospitals. The Grenfell system has been recognized as a model for the delivery of health care throughout Canada's North.

The emphasis of the program is gradually shifting from the acute care of disease, often in an emergency situation, to public health and preventive medicine. The results of this trend towards preventive health care are just beginning to be seen.

by radio transmitter. His job is to determine if there are any medical problems or concerns and to inform the nurse of the progress of any patients from Cartwright who have been hospitalized.

A physician from North West River Hospital visits Cartwright approximately once a month. A clinic is held at this time and all patients who need to see him have appointments booked. At least once a year a dentist also visits the community.

Patients who need hospitalization are usually sent to North West River by float or ski plane. The weather often poses a threat to the health care of the villagers because storms and heavy fog are common along the coast. Sometimes patients must wait in the nursing station for several days before they can be transferred to the hospital.

The Role of the Nurse Practitioner

In an isolated setting the nurse is responsible for providing primary health care to the entire community. In order to do this, the nurse in Cartwright sees people both in the nursing station and in their own homes. Patients are seen in the clinic on an ambulatory, walk-in basis at designated clinic times. A general clinic is held every day, Monday through Saturday.

Each week the nurse holds a well-baby clinic and a pre- and post-natal clinic. Specific times are kept free of responsibilities at the nursing station to allow for home visits.

In addition to these regular commitments, the nurse must be available at all times, twenty-four hours a day, seven days a week, to see people on an emergency basis. She can never be far from a telephone because she might be needed at any time.

Occasionally patients have to be admitted to the nursing station. Their care adds another dimension to the nurse's role. Here the nurse has the help of local girls who work as nurses' aides and perform some routine nursing tasks for these in-patients. The aides attend to the patient's hygenic needs, take temperatures, serve meal trays and are available to answer the patient's bell. But the nurse has the full



responsibility for supervising the care and giving some nursing care herself. She monitors changes in the patient's condition and, as often as is necessary; she alters the treatment plan in consultation, by telephone, with the doctor in North West River. Depending upon the patient's condition she assesses him/her more or less frequently, not only during the day but also at night.

Our Contacts with Patients

In order to assess the responsibilities of the nurse practitioner in an isolated setting Jane and I recorded each meeting we had with patients.

During the two months we were in Cartwright we saw 356 patients. All of these patients were seen by one of us individually or in the company of Jean, the regular nurse. A few patients were attended to only by Jean and they were not included in our study. Nor did we include patients examined by physicians visiting Cartwright for clinics.

We saw some patients more than once and recorded each encounter as a separate visit even when there were several in one day. During the months we were there five patients were admitted to the nursing station; our numerous contacts with these in-patients were not recorded.

We saw 50 of the 356 patients during home visits. Most of these visits were similar to those made by a public health nurse in any other part of Canada: 32 of the 50 visits were made to the elderly or to those with chronic illnesses. Here we checked the patient's health status and did any nursing interventions that were indicated.

Another 13 visits were made to people with acute health problems. Some were for the initial assessment of a complaint and others were to check on patients who had recently been seen in the nursing station and were now at home.

Several visits were made because the patient concerned had no way of getting to the nursing station whereas we had access to a car and could get to them. The smallest number of home visits, five, were made just for the exchange of information. We made these visits because some of the citizens of Cartwright didn't have a telephone.

Analysis of Clinic Visits

- *Assessment and Treatment*

We saw the greatest majority of patients, 306, (or 87%) in the clinic. People came to the clinic for a wide variety of reasons. (See Table 1) The most common reason was for assessment and treatment of a specific complaint; 134 patients were seen for this reason.

We categorized specific complaints according to the part of the body involved (See Table 2) and in this way we were able to determine which body systems were most frequently assessed and treated. It was interesting to find that virtually all of the body systems were included, although the frequency with which they were the sites of complaints varied.

The two most commonly observed problems were those involving the ear, nose or throat (20%) and the respiratory system (18%). Problems in these areas were usually the result of infection.

- *Prescriptions*

The second most frequent reason for people coming to the clinic was to get prescriptions refilled. This accounted for 96 visits, (31.5%). There is no pharmacy in Cartwright, therefore everyone who takes medication has to go to the nursing station for it.

People were usually given enough medication to last one month. This meant they were always seen at least once a month by the nurse. At this visit Jean usually did more than just refill the prescriptions; she took time to ask about the patient's general well-being and assessed his/her health status. This meant patients with a history of hypertension had their blood pressure checked, weight taken and ankles assessed for edema each time they came for their antihypertensive medications. All patients with a chronic illness were monitored in this way and therefore any problems associated with their condition could be discovered early and an appointment could be made for the individual to see the physician.

- *First Aid*

We saw twenty patients (6.5%) in the clinic for first aid including suturing of wounds. Most of these patients had abrasions or lacerations that just required cleansing and possibly the application of an antibiotic ointment. In another setting some of this might have been done by a family member but since the nurse was available she was used for this service. Five of the twenty patients had lacerations serious enough to require sutures. Twenty-six patients (8.5%) were seen for dressing changes or the removal of sutures. These treatments are usual nursing activities.



Photos courtesy of International Grenfell Association

Implications for the Nurse Practitioner

Many of the patients we saw had chronic illnesses. As nurses we had to know what to look for when assessing a patient and the usual response to treatment. Occasionally a slight modification of the patient's treatment regimen was necessary and we had to be prepared to initiate this. But more often than not the role of the station nurse was to monitor the patient's condition, reinforce the need for therapy and encourage compliance with the treatment program.

Not all patients had chronic illnesses. We also had to be prepared to give emergency care. As the only health professionals in the town nurses must be ready to treat any emergency, whether cardiac arrest or laceration requiring suturing.

Midwifery experience would be a definite asset for the nurse practitioner in an isolated setting. Although no deliveries occurred while we were in Cartwright, Jean had to be competent in assessing the antenatal patient and monitoring the progress of a pregnancy. She had to recognize patients at risk so she could make the appropriate referrals.

Occasionally the equipment needed for laboratory tests which would confirm a suspected diagnosis was not available in the nursing station and the patient had to be flown to North West River for examination. Most laboratory specimens had to be sent away for analysis. It sometimes took several weeks before the results were returned, therefore, it was often necessary to commence treatment prior to receiving complete laboratory results. In these cases it was very important that we gather data about the patient through his history and physical assessment and make appropriate decisions about management based on an interpretation of this data.

The assessment of patients required the utilization of the skills of inspection, palpation, percussion and auscultation. Because there is no doctor present to validate her findings, a nurse in an isolated setting must be confident in her ability to use these skills and recognize abnormal findings. A physician can be consulted by telephone but his assistance can only be helpful if the information he receives from the nurse is accurate and knowledgeable.

Assessment of the eye, ear and neurological system necessitated skill in the use of the ophthalmoscope, otoscope and reflex hammer.

Medication was administered to, or prescribed for, 109 (or 81%) of the 134 patients seen for specific complaints. We found that a good knowledge of pharmacology was essential for the nurse to function adequately in this setting. For example, it was necessary to know what bacteria caused a particular type of infection, the best antibiotic to combat this bacteria, the usual dosage and the preferred length of treatment.

We found that as well as being concerned with the care of individuals it was essential for the nurse to be concerned with the health of the community. She had to be cognizant of the health and learning needs of the community and prepared to take a leadership role in relation to these needs.

It has long been recognized that nurses in outpost nursing stations require certain skills and knowledge beyond those usually acquired in Canadian basic nursing education programs.[1] In Cartwright the nurse was responsible for diagnosing and managing patients' problems, performing some minor laboratory procedures and delivering most multiparous women with uneventful pregnancies. In order to meet these responsibilities she had to be skilled in history-taking, physical assessment and decision-making. She also had to be knowledgeable in pharmacology, community nursing and the management of acute and chronic illnesses.

Our experience in Cartwright provided an excellent opportunity for us to become more familiar with the knowledge and skills required of the nurse in an isolated setting and to gain experience in the role of the nurse practitioner.

Table 1

Care Required by Patients Seen in Clinic

	Number	Percentage
Assessment and treatment of specific complaints	134	44.0%
Refill of medications	97	31.5%
Dressing change or suture removal	26	8.5%
First aid including suturing	20	6.5%
Antenatal or postnatal check	17	5.5%
Advice	6	2.0%
Cast application or removal	3	1.0%
Well baby immunization	3	1.0%
Total	**306**	**100.0%**

Table 2

Patients Seen for Assessment and Treatment of a Specific Complaint

Chief Complaint	Number	Percentage
Ear, Nose and Throat	27	20.0%
Respiratory	25	18.7%
Gastro-intestinal	21	15.7%
Integumentary	16	12.0%
Dental	11	8.2%
Genito-urinary	9	6.7%
Musculoskeletal	9	6.7%
Cardiovascular	6	4.5%
Eye	6	4.5%
Neuropsychiatric	4	3.0%
Total	**134**	**100.0%**

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NEW HORIZONS FOR NURSING

看護の限りない可能性を求めて

part one

"Professional responsibility: an international concern"



Photo courtesy of International Council of Nurses

Some of the most energetic discussions in nursing today focus on professional responsibility and expanded horizons in this area. Recognizing this, ICN's final plenary session was entitled *"New Dimensions of Professional Responsibility."* It was a discussion of some of the critical issues involving increased responsibility: Nursing Authority, Rights of Nurses and Individual and Collective Responsibility.

The talks were informative, but they also demonstrated the International Congress's ability to allow nurses to share information of common concern to all. Excerpts from papers prepared for this session are presented here for your increased awareness.

There can be no question that nurses are in a unique position to speak and to act with authority. Nor can there be any doubt about the need for nurses to carry their full weight during the current realignment of power relations in the health system. The fact that they have not yet done so, according to **Huguette Labelle,** former president of the Canadian Nurses Association, must be attributed to lack of confidence in their own ideas, in the strategies they have been able to develop and in their ability to influence others. Labelle, formerly Principal Nursing Officer, Health and Welfare Canada, is currently director general, Policy, Research and Evaluation Branch, Indian and Eskimo Affairs, Ottawa, Canada. "Our capacity to influence is enormous if only we can develop the confidence to mobilize our own collective and individual potential. Increasing our capacity to influence — in other words, our power — is morally right and desirable to the extent that this power is utilized in improving the health of our population.

For the individual nurse, accountability means answerability and responsibility for outcomes of nursing actions rather than being responsible to an immediate supervisor for these actions.

"Nursing authority is a vital tool for individual nurses and for the nursing collective. Four factors affect nursing authority, including knowledge, accountability, mastery of competent interpersonal relationships and power.

"The first factor associated with authority is extensive knowledge of one's field along with a good understanding of related areas. Credibility as a respected practitioner comes from demonstrated excellence based on sound knowledge. We have only to recollect our own feelings when confronted with professional incompetence, in order to weigh the primacy of this factor.



"The second factor associated with nursing authority is accountability. Collectively nurses at the level of institutions and professional associations foster accountability through the development of codes of ethics, standards of practice for entry into the profession, and evaluation criteria. For individual nurses accountability means answerability and responsibility for outcomes of nursing actions rather than being responsible to an immediate supervisor for these actions.

"To have possession of knowledge and to be accountable without mastery of competent interpersonal relationships is like owning an automobile and insurance without being able to drive.

"Within nursing fear of each other is detrimental to understanding and close collaboration. It also leads to prejudice. The fear of each other held by nursing service and nursing education, by graduates of hospital programs and those of university and college programs, by nurses working in hospitals and those working in primary health care settings eventually leads to prejudice and lack of openness.

"The final factor associated with authority is power. Nurses must realize the importance of the political dimensions of public policy setting and of development of operational policies. In exploring strategies, nurses must plan to influence the direction in the early stages of development or at best to influence initiation of specific policies and statutes instead of being reactive once these have been formulated."

Mary E. Patten, the federal secretary of the Royal Australian Nursing Federation and former chairman of the joint ILO/WHO conference on conditions of life and work of nursing personnel, told nurses attending the ICN Congress, "rights of nurses in many countries around the world have been trampled on, neglected and opposed." She urged nurses to make a personal commitment to human rights and to the rights of nurses.

"The nurse as any other individual, can meet his or her obligations appropriately only when acting in his or her own right on the basis of his or her own values, beliefs and knowledge and not simply responding to the expectations of others.

"The rights of nurses are transgressed daily with demands to perform procedures with which they are unfamiliar, demands that their vision of the future conform with the vision of others, and constant demands to stretch available staff to cope with caring for more people than is just.

... the rights of nurses are also transgressed daily by nurses themselves who, as individuals, are content to act in response to the expectations of others rather than on the basis of their own values, beliefs and knowledge.

"But the rights of nurses are also transgressed daily by nurses themselves who, as individuals, are content to act in response to the expectations of others rather than on the basis of their own values, beliefs and knowledge.

"This attitude has done a great deal of harm to nursing, and, I believe, to patients and clients of nurses. It stems from the transgression of the fundamental right of human beings to act on their own physical, psychological, ethical, moral, intellectual and spiritual needs.

"Clearly, the rights of individuals are dependent on pre-conditions existing in society and from this it must follow that until and unless these pre-conditions exist, it is a mockery to speak about the rights of individuals, let alone the rights of nurses. One must conclude also that the rights of nurses in such societies can hardly be met without changing those conditions which thwart freedom to speak, justice, honesty, orderliness of the group and so on.

The good nurse is selfish to the point of maintaining and developing his or her own character structure with no need to fear the unfamiliar or simply respond to the expectations of others.

"The good nurse is selfish to the point of maintaining and developing his or her own character structure with no need to fear the unfamiliar or simply respond to the expectations of others. The selfish element is crucial to the ability to work *with* people in the promotion of health, the prevention of illness and the care of the sick; working *with* people instead of doing things for them or to them.

"In moving to further the rights of nurses we have a responsibility and right as nurses to examine some of the issues underlying our planning and action, whether that planning and action is directed specifically towards improving pay, education or the social and cultural conditions in which nursing personnel work. The compression of mankind need not give rise to increasing oppression and should in fact release an enormous quantity of psychic energy where individuals seek not only to enjoy more and to know more but to be more. The technology now at our disposal and in particular the advent of the computer can be used to this end rather than contribute to the "Big Brother" world of George Orwell's *1984.*"

Anne Zimmerman the president of the American Nurses Association called on nurses of the world to each play a part in "the evolution from individual accountability to one world of nurses accountable not only to the consumer but to and for each other." Executive director of the Illinois State Nurses Association for several years, Zimmerman has served as chairman of the Commission on Economic and General Welfare of the American Nurses Association and received ANA's honorary membership award for her work in promoting and defending the right of nurses to organize and bargain collectively.

"As members of our professional organizations and of the International Council of Nurses we can see the results of our struggle to promote health and the care of the sick internationally. It is a humbling thought but testimony to the future of the nursing collective — its energy, its progress and its potential as the universe of collectivity.

"No matter where we practice nursing we are bound to certain professional responsibilities (both collectively and individually) as a result of our commitment to the constant improvement of health care.

"Fulfilling these basic responsibilities and achieving common goals and objectives are dependent upon the ability of nurses, as a collective body, to bring about innovations and changes. This concept of the "nursing collective" gives the profession a homogeneity of purpose, policy and method of operation. Within the collective, differences can be debated and resolved, trends can be set, and nursing's authority can be strengthened.

"The nursing collective has an obligation to modify and expand the scope of its practice in light of new demands for health services and technological and scientific innovations. Consequently,as nurses, we must assume responsibility for identifying significant goals and priorities and initiating innovative nursing programs aimed at satisfying projected needs for health and nursing care.

"One responsibility which has always faced the nursing collective is developing an effective method of self-regulation. If the nursing profession is to assume a primary care role and have a serious impact upon the delivery of health care, nurses must be in a position to assure the public of quality nursing care.

As a health professional and concerned citizen, each nurse has an obligation to work toward improving the health care system.

"Since the public holds the profession accountable for the competence of its practitioners, the nursing collective has an obligation to establish certain standard authoritative statements by which the quality of nursing practice, nursing service, and nursing education can be judged. To implement and enforce these standards, the nursing profession must be self-governing.

"Individually and collectively, the nurse's first responsibility is to the consumer — our patient or client. Within the nursing environment, we must daily make informed decisions and must have the autonomy necessary to determine our own professional activities. Nurses in practice must guarantee that patients receive professional nursing care. As members of the nursing collective, we cannot postpone accountability.

"Closely allied with the quality of a nurse's practice is his or her ability as an innovator. As a health professional and concerned citizen, each nurse has an obligation to work toward improving the health care system. When nurses have successfully integrated all these concepts into their daily practice and their approach to nursing, they can begin closing the gap between what really is and what ought to be — quality care for every person in every setting. But accountability begins with the individual nurse committed to caring for the patient and to carrying out the standards of practice. The issue demands dialogue, discourse and decision-making before it can have real meaning. We must also be accountable to each other — to share new approaches with our colleagues, to talk to each other and once begun, to carry on the dialogue."



TOKYO 77 ICN

NEW HORIZONS FOR NURSING

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part two

"Nursing practice around the world"



The International Council of Nurses exists to serve all nurses — regardless of nationality, race, creed, color, politics, sex or social status. One of its most important functions as an international organization is to provide a vehicle for nurses throughout the world to share common interests and work together to develop the contribution of nursing to the promotion of health and care of the sick. Nowhere is this sharing more apparent than during a Congress such as the one which took place in Tokyo last June.

All of the Congress participants had much to offer their fellow nurses but one session in particular seemed to offer the nurses who attended an unparalleled opportunity to discover what it's like to be a nurse in another country, what we have in common and what we can do to help each other. Its title was self-explanatory: *Nursing practice around the world.* Excerpts from the papers prepared for this session are presented here for your information.

AFRICA

***Eunice Muringo Kiereini** is chief nursing officer of Kenya. A graduate of Southampton General Hospital in England, she obtained her midwifery certificate from Simpson's Memorial Maternity Unit in Edinburgh, Scotland and her diploma in nursing education/administration from the New Zealand school of advanced nursing in Wellington. She is an ex-officio member of the Nursing Council of Kenya and represented the Government of Kenya at the International Labor Conference in June in Geneva.*

"Nursing in Africa faces the same forces of change and challenge encountered by representatives of the profession in other countries around the world — but with important differences caused by imbalances in technological developments and material resources. Following the setback caused by colonialism, independent African countries are now beginning to establish well-planned health care delivery systems and independent nursing organizations and health services are a top priority since officials believe that, in order to be strong a nation must be healthy.

In Africa, we have had a corps of 'barefoot nurses' serving the people for many years.

"One of the features of the new system is a growing emphasis on 'family health' as opposed to care for the individual. This new concept has been well accepted in Africa because of its practicability and also because of the traditional emphasis on the family and its extended role.

"In Africa we have had a corps of 'barefoot nurses' serving the people for many years. Nearly every country in Africa has experienced difficulty in persuading doctors to serve in rural areas and unsuccessful efforts in this area are now being abandoned in favor of giving this responsibility to other types of health workers.









The nursing personnel of Africa have accepted the challenge and taken their position in the forefront of providing primary health care — in the jungles, mountains and desert lands. These are the nurse clinicians of Africa. They function on their own and make vital decisions without referral to anyone.

"Most countries in Africa are now preparing community nurses both at registered level and at the enrolled level. This is happening in Nigeria, Ghana, and Kenya. Many other countries are planning to start this program. The community nurse is a practitioner in her own right. She is given formal preparation to be able to diagnose, prescribe and treat. Family health offers us an intermediate dimension that is both easier to grasp than public health and more operational than medicine applied to the individual. If we can find a way to apply this attractive concept in practice, we might well have at our disposal a logical and an important link between two extremes and our ideal 'take-off' point for a coherent prophylactic and curative approach towards many health problems.

In no other field has the emancipation of women been of greater importance than in nursing.

"Another development which has taken place is the preparation of male nurses. In Kenya we have even gone a step further in preparing male nurses in the field of obstetrics where they are doing 'deliveries!' To begin with this concept was opposed even by the nurses

themselves, but when one argued that there was no difference between a male nurse and a male doctor doing obstetrics, the idea was gradually accepted. We have now male nurses working hard with their female colleagues as practising midwives.

"In tracing the changes in nursing practice we are aware that the struggle for political, economic and educational freedom of women is entangled in the fight for professional advancement. In no other field has the emancipation of women been of greater importance than in nursing. Nurses have been encouraged to struggle for greater autonomy in practice and freedom from physicians' control. Nurses have demanded better terms of service and improved working conditions. There has been a definite and calculated move by nurses to control nursing affairs in the fields of service, education, administration and research.

"For many years, in Kenya, we have been unhappy with the methods used in our staffing patterns, particularly in the hospitals. 'The Kenya Nursing Project,' is an attempt to systematize and formalize nurse staffing methodology. Patients are classified on the basis of their nursing needs as 'minimum care,' 'moderate care,' and 'intensive care.' The Project will try to come up with tools which will improve the quality of nursing practice in in-patient units of government hospitals. A committee known as the 'Nursing Standards Committee' has been set up to define standards for hospital nursing care.

"Africa is a continent which has had many and varied developments. The scope for nurses is absolutely unlimited."

EASTERN MEDITERRANEAN

Enaam Abou-Youssef *is associate professor at the Higher Institute of Nursing, University of Alexandria in Egypt and nurse-midwife educator at the African Health Training Institutions Project, Carolina Population Center, University of North Carolina, U.S.A. She is a member of the nursing advisory panel for the WHO Eastern Mediterranean Regional Office and has served as short-term consultant to several seminars and meetings on family health and manpower development organized by WHO headquarters and by the Eastern Mediterranean Office.*

"Nursing practice in the Eastern Mediterranean countries has a definite contribution to make to the total development of each of these countries. Nursing activities, previously confined to the care of the sick and disabled in hospitals, now are extending into rural health centers, factories and industrial plants, schools, maternal and child health centers and nursing personnel in many countries are involved with other types of workers in health and community development programs.

"The Eastern Mediterranean area comprises Ethiopia, Iran, Israel, Jordan, Lebanon, Pakistan and Egypt, an area of 4.8 million square kilometers. Forty-five percent of the area's 167 million people are under 15 years of age.

"Nurses have been involved in national health programs with community orientation with specific goals such as family planning programs in both Egypt and Pakistan, and primary health care programs in both Iran and Ethiopia.

"In hospital nursing, changes have been taking place to improve the delivery of service. In this domain, different levels of nursing personnel are cooperating in the care of groups of patients. In both Lebanon and Jordan, the team approach has been very successful in overcoming the shortage of highly qualified nurses and yet maintaining the same quality of care needed by the patients. The complexity of the care delivered in certain hospital units such as premature babies, ICU, CCU, etc., has necessitated that nurses perform certain functions which require special knowledge and skills. New categories of specialized nurses are operating in these units and carrying out highly technical skilled nursing tasks such as monitoring patients.

Nurses in the Eastern Mediterranean have been assuming the responsibility for certain activities traditionally known to be within the domain of medical practice.

"With utilization of medical technology as well as development of nursing sciences, specialization in nursing practice is getting to be more and more a reality in the Eastern Mediterranean area. Nurses have been assuming the responsibilities for certain activities traditionally known to be within the domain of medical practice. One example is the administration of I.V. solutions. In both Lebanon and Egypt legal action has been taken to allow nurses to perform I.V.s. It is my belief that, as development progresses in the different countries of the Eastern Mediterranean region, nurses will find more opportunities to expand their roles in order to meet the various health needs of the population.

"Another area of nursing practice that has advanced greatly in this area is disaster and emergency nursing care. The fact that all the countries of this region have been involved in border disputes as well as encountering natural disasters such as floods and earthquakes imposed certain demands to which nurses did respond. Courses have been organized for training practitioners in the different concepts and skills related to emergency and disaster care. As a result, the efficiency as well as effectiveness of nursing staff at times of emergency has been acclaimed in many of the official reports.

"Though problems and barriers do exist and frustrate nurses who are interested in change and innovation, there are also indications and factors which tend to be encouraging. Among these factors is the vital interest of all sectors of the population in health and their demands for better and more nursing services, of all different kinds and at all levels."

EUROPE

Kirsten Stallknecht *is president of the Danish Nurses Organization and also vice-president of the Joint Council of Danish Public Servants and Salaried Employees Organizations of Denmark. A graduate of University Hospital in Copenhagen, she also holds a certificate in administration from the school of Post-basic Education at Aarhus University in Denmark. (Paper delivered by Inge Anderson, first vice-president of the Danish Nurses Organization).*

"The growth of wealth in Europe in the 1960's, the increasing industrialization and change in the demographic pattern (more people over 65), have caused the population to increase their demands on the level of service of the social and health service systems. But the economic crisis has also made politicians from all countries look very carefully at the resources used.

In Europe nurses are both divided and united in various groups as to social, cultural and political systems, and within these groups they work for higher quality and uniformity in nursing in Europe.

One group, the oldest, covers the Nordic countries (Denmark, Finland, Iceland, Norway

and Sweden). The NNF (Northern Nurses' Federation) was established in 1920. Its main purpose was to evaluate the education of nurses according to the needs of society, and in such a way that the education of nurses in the five countries would be equal. Since then, cooperation has expanded to include subjects such as professional issues, salary and employment conditions and research.

"Another group, the ENG (European Nursing Group), was established in 1947 and covers Austria, Belgium, France, Germany, Greece, Ireland, Italy, Luxemburg, Netherlands, Portugal, Spain, Switzerland, United Kingdom and Yugoslavia.

"The main purpose of this group is to collect information about the current situation and future trends in education of nurses in Europe.

"Educational questions have been the most important subject for both groups, and following the establishment of the European Economic Community (EEC) it was natural for the two groups to contact one another. The first contact took place in 1969, and a third group, the PCNL (Permanent Committee of Nurses in Liaison with the European Economic Community), was established in 1971. The nine countries in the PCNL are Belgium, Denmark, France, Germany, Ireland, Italy, Luxemburg, Netherlands and United Kingdom.

"During the last twenty years nurses in Europe have come to realize that further development of nursing standards and nursing practice depends on the establishment of nursing research. However, understanding of and steps taken towards nursing research have been sporadic as a whole, perhaps due to the fact that education of nurses has basically been given in nursing schools in hospitals, and not at the university level.

"The economic crisis in Europe has caused a reduction in the resources used for health services. This situation naturally influences the service level, and nurses must, whether they like it or not, find new ways to practice if standards of nursing practice are to be maintained and developed. Therefore it is tremendously important that nurses participate in decisions about priorities and the use of resources.

"One might well ask 'What should nurses in Europe stake the future on, and how can they do it?' One of the answers could be that nurses must go on working on developing research programs; programs in which the fundamental aim is to find out how health care and nursing practice can be developed in accordance with medical and technical progress, but also in such a way that the human and social relations between nurses and the population are not lost.

"Another answer could be that nurses should try in as many ways as possible to strengthen their influence both as a group and as individual nurses in daily nursing practice. It is not a question of power, but of the necessity of the fact that politicians in all European countries realize that good health care standards cannot be provided without a well-educated and freely-speaking nursing profession.

"In the coming years the advance of medical technology should naturally be followed by similar advances in nursing care, and society should develop a health care system in which the population as a whole is covered adequately in daily life, but it should not be a health care system which enables a hospital to carry out heart transplantations when the ordinary working man may not have access to necessary care for his children."

NORTH AMERICA

***Rozella M. Schlotfeldt** is professor of nursing, Case Western Reserve University, Cleveland, Ohio, U.S.A. She has served on numerous national advisory councils, commissions and boards in the United States dealing with nursing and health issues and is the author of over 90 individual publications in professional and scientific journals, book chapters, monographs and research reports.*



"There is considerable evidence that a critical mass of nurses in Canada and the United States have developed a high degree of professional self-awareness and have become increasingly assertive concerning the need for, the value of, and the consequential nature of professional nursing practice. Evidence indicates a number of other changes:

- Nurses are growing increasingly respectful of their need to demonstrate independence as practitioners of a professional discipline. They have set standards for and are eager to be accountable to those they serve for the gamut of nursing practice.
- Nurses are increasingly concerned with the delivery of scientific as well as humanistic nursing care and are actively involved in seeking to establish and enlarge the knowledge base for the gamut of nursing practice.





Photos courtesy of the Canadian Habitat Secretariat and International Development Research Centre

• Nurses are experimenting with new organizational arrangements with a view to finding effective and efficient means to deliver high quality health care.

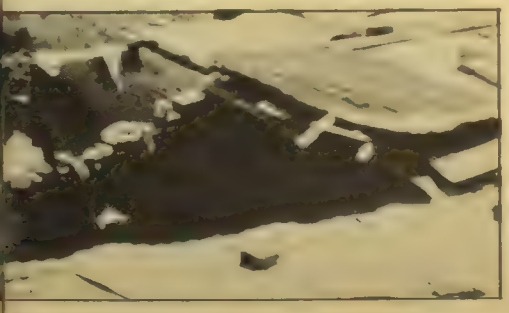
• And last, nurses are becoming increasingly involved in the politics of health care and gaining in society's recognition of their earned right to influence the health care system.

"Nurses, like other health professionals, have been adversely affected by people's fascination with illness and by their failure to value health sufficiently. As a consequence, North American society has become 'medicalized' and the so-called health care system has had its resources focused primarily on providing illness care, in contrast to health care. The consequence has been to emphasize patients' dependence, rather than human beings' essential strengths.

"The Canadian government has given great leadership in pointing up the need for emphasizing each individual's responsibility for seeking to be healthy and for the health care system to focus on health promotion as well as on disease detection, prevention and cure. That trend is also developing in the United States. Inasmuch as nursing's mission as a field of professional endeavor is, and always has been, to assess and enhance the health status, health assets, and health potentials of human beings, it is both inevitable and timely that nurses' professional self-awareness has been awakened.

"Nurses' professional self-awareness has taken several forms. Some have claimed an 'expanded role' and have alleged that assessment skills, particularly as related to physical assessment in 'primary care encounters,' represent delegated medical tasks; others have claimed that assessment of the physical, social, and emotional health status of people has traditionally been an integral part of the armamentaria of nurses who fulfill the professional's role.

It is both inevitable and timely that North American nurses' professional self-awareness has been awakened.



"There is now general acceptance that nursing, like all other professional practice disciplines, requires educated practitioners who can apply selectively and with judgment vast amounts of knowledge. It is recognized that properly trained assistants can work under the guidance and surveillance of professionals who are responsible for practice.

"Canadian nurses recognized their responsibility for all of nursing practice long ago and their license-granting procedures clearly differentiate professionals from those who assist them. It was only a decade ago that nursing in the United States took the position that two types of nursing practitioners should be differentially prepared and clearly designated. Individual states are now beginning to take action so that by 1985, all persons entering professional nursing practice complete requirements for a baccalaureate or higher degree.

"There is growing acceptance of the value and cost effectiveness of 'primary nursing' in hospitals. A primary nurse gives total care to a small group of patients on a twenty-four hour basis by assuming responsibility for assessing and planning for the care needs, providing and evaluating the care, and being accountable for all ministrations, provided personally and by nurse-associates. Several evaluations have demonstrated the superiority of nursing care rendered and the enhanced satisfaction of patients and nurses when primary nursing is in operation.

"The trend toward staffing hospital units entirely with professionals is in evidence both in Canada and the United States as a means to ensure acceptable quality of service to hospitalized patients who typically require sophisticated care.

"Nurses are beginning to be recognized as competent, primary care providers whose talents can, if properly utilized, enhance the amount and quality of health services provided. Additionally, by making competent assessment and providing effective interventions, they make substantial contributions to reducing the costs of care.

WESTERN PACIFIC

Hsin Hsin Chung *is director of nursing service, National Taiwan University Hospital. She obtained her diploma in nursing from St. Luke's College of Nursing, Tokyo, and studied for her B.S. at Wayne State University College of Nursing in Detroit, U.S.A., and her M.S. at Washington University College of Nursing, St. Louis, U.S.A. She was president of her national nurses association from 1971-73.*

"For the past three decades, the nursing profession in our country has accomplished a remarkable development. A new educational system is being adapted to meet the urgent shortage of nurses and many new nursing schools have been established. Four-year collegiate courses for nursing as well as five-year junior college of nursing and midwifery courses have been established both in the public and the private universities and junior colleges. All the nursing and midwifery schools are under the direct control of the Ministry of Education. New hospitals are being built and there is a network of health stations located in each township throughout the island.

"However, accomplishment has been measured in comparison with the developed countries and therefore, in spite of all the rapid and new developments, there seems to be a vacuum or a gap to be filled if we wish to continue to grow as a profession and to maintain the profession's continuity.

"Modern industrialization and the advancement of technology has made it possible for the people of our country to enjoy a period of relative affluence and peaceful prosperity. The standard of living has been raised; major causes of illness have changed from acute contagious diseases to chronic conditions; the people are better informed and finding more resources available to maintain healthful living. But within the culture in which we live and offering services to the people as a helping profession, we should not be ignorant about the folkways of maintaining healthful living.

"In looking toward the future, may we suggest that the Oriental way of life might be adopted to enrich the quality of care. Nurses can cultivate more sensitivity towards others' ways of life and learn to regard the client as a whole person with his particular beliefs, health habits and position in his family and milieu. Nurses who are defining a new and expanding role should look at their daily performance more closely and listen to what the people that they are caring for really say and ask for.

"In the process of delivering care we have been mainly concerned with the way in which care is given and have often overlooked the way this care is received... Though we have much to learn from the West and have benefited a great deal, we may have unknowingly imposed on our people, our standards of good nursing, although these may not be exactly what people appreciate most as helpful care for them. For instance, we think that morning care should include a bath for a bed patient, but there are very few patients in our country who can appreciate a bed bath in the morning because, according to our custom, a bath is usually taken in the evening.

In contrast to the active, exact and decisive Western way of life, the Oriental way seems more inclusive and has more appreciation for the totality.

"The power of scientific discovery has led us to believe that the logical way of thinking should take precedence and irrational superstitions should be totally discarded. Professional performance should be in accordance with scientific principles which call for preciseness, punctuality and predictable consequences. The nursing profession has followed the path of scientific endeavor with some degree of success. But in the area where our professional members are trying to relate to our fellow men, in playing the role of a helper in restoring health for other human beings, scientific knowledge has not yet given us the full answers and we need to look for some other elements elsewhere.

"The Oriental way of life appears to be more reserved, with appreciation of tranquility and a tendency to deal with others in a manner which is more passive and resigned. It emphasizes natural harmony and expects one to be sensitive to his position in relation to his surroundings. Oriental culture, on the whole, places a great deal of emphasis on the return to nature. There is no doubt that there is much room for further study of the folkways of maintaining healthful living and helping people regain health. As members of a helping profession for health, we should take time to find out exactly what does help people, especially to keep the older age group active and alert.

"It makes a great deal of difference in caring for a person whether one is loved and respected in a family or rejected and feared. We would like not only to equip our nurses with more scientific theories and newer techniques, but particularly to encourage them to become more alert and sensitive to the needs of others. The health worker without a heart and a will is like a person without a life and acts as though he or she is a living machine. We need a pair of hands and a bright head as well as a warm heart and a strong will of determination to become useful nurses to help in restoring health to others."

SOUTHEAST ASIA

***Hilda de Silva** is Chief Nursing Officer, Medical Services, Sri Lanka and president of the Sri Lanka Nurses Association.*

"The nursing profession was well known to the people of Asia long before the introduction of modern nursing in the 19th century by Florence Nightingale. Then in 1878, the first attempt to introduce a scientific system of nursing into the hospitals of Sri Lanka was made by the appointment of a superintendent and a trained nurse from England. From that time until 1952, the schools of nursing in Sri Lanka were headed by English and American nurses, but at present all the schools are administered by Sri Lanka nurses.

"Advances in medical science have placed emphasis on team work in dealing with hospitals and patients. This team consists of specialists, physicians, pathologists, surgeons, anesthesiologists and nurses, as well as engineers, architects, mathematicians, etc. The nurse is an indispensable member of this team. Both the physician or surgeon and nurse are expected to share knowledge, technology, decision-making and control of resources with one another, with other categories of health personnel, and with the patient and his family.

"Present-day nurses in Sri Lanka are very keen on continuing their education with a view



to improving patient care, and refresher courses are being conducted regularly for them. Another new feature in nursing education is the in-service program conducted in some provincial hospitals in Sri Lanka.

"In India the nursing curricula emphasize the integration of public health in the basic nursing program. This was the first step in attempting to meet India's health needs and was instrumental in spreading nursing from the confines of hospital care to preventive care and promotion and maintenance of community health.

"The high maternal mortality rate in Thailand led to the nursing emphasis in the early days on maternity and infant care. Thailand has developed a career ladder pattern of nursing education from practical nursing programs to baccalaureate programs, special attention is being paid to develop programs which include nursing administration, teaching, cardio-thoracic



nursing as well as medical and pediatric nursing. Higher education programs in nursing administration and clinical nursing leading to a Master's degree are carried out for nursing personnel in health clinics in order to prepare them for curative functions in areas where doctors are not available.

"Family health is included in all courses in nursing and midwifery. Since the population explosion is one of the major problems facing Southeast Asian countries today and about 80% of the population live in rural areas, primary health care is given high priority. In Thailand, nurses are allowed legally to perform curative functions in the rural clinics where physicians are not available and are controlled by protocols. The referral system has been a great success there. Insertion of intrauterine devices as a method of preventing pregnancy in family health care is also carried out by nurses.

"Nurses throughout Southeast Asia are now working in a number of specialized fields — neurosurgical care units, coronary care units, urological care units, plastic surgery and burn units, and ENT units.

"In Burma the preventive aspect and community care are given priority. Health education is also given more emphasis. The nurse is no longer confined to the hospital ward only; home visits for follow-up care and field work are now included in her training."

SOUTH AND CENTRAL AMERICA

Irma Sandoval Bonilla *is associate professor and director of the school of nursing, University of Costa Rica in San José, Costa Rica. She is currently studying for her doctor of philosophy degree at the University of Costa Rica and was awarded a 3M Nursing Fellowship by the ICN in 1974. She was president of the Nurses Association of Costa Rica from 1972-74 and is a member of the National Council of Nurses of Costa Rica.*

"We cannot separate the innovations in nursing from the changes that have taken place in our societies. They are changes that in the health field have modified, amongst other things, the concepts of health, utilization and delivery of services and health policies. At the moment, nursing is passing through critical times, influenced by both external and internal factors. External changes, such as new health policies, the demand for more and better health care for all people, the need to bring health care to rural areas, a fuller awareness on the part of politicians and authorities of what health means for the development of nations, and many other changes have obliged or are obliging the nursing profession to make drastic changes in the traditional patterns as much in the education of nurses as in the delivery of services. These outside factors which are independent of the nursing profession are more important and significant than the change factors evolving within our profession.

"I believe that the new concept of health care, intimately linked to the factors previously mentioned, will be understood to the degree that we accept or reject the fact that nursing is determined by the character of the social structure prevailing in our respective countries.

"Within the new conceptual framework of the right to health, countries have proposed changes in their health systems. As a result, there have been changes in the role of the nurse. Primary health care has been qualified by national and international health bodies as the point of entry into the health care system. It is acknowledged that this care must be intimately related to the patterns of life and needs of the community and completely integrated with other sectors involved in the social, political and economic development in the different countries.

"In nursing, it is hoped that the extension or expansion of nursing's new role will be fulfilled within the context of primary health care. Some countries have stated whom they consider as a primary care nurse. For example, in the United States and Canada this new kind of nurse has been designated as a "nurse practitioner;" she is considered as a specialized nurse capable of performing some of the functions that until recently were only performed by physicians.

We cannot separate the innovations in nursing from the changes that have taken place in our societies.

"In Canada, the Canadian Nurses Association and the Canadian Medical Association issued a statement in 1973 accepting the new functions of nurses and establishing norms for development within the new spheres of activity. Primary care develops within the individual context of each country with the characteristics and peculiarities typical to each one. The ideal would be for nurses functioning in this extended role to have the authority that the responsibility assumed demands.

"The legal view of nursing is complex. More energetic action is required on the part of nurses to overcome the reserve expressed about their extended role and to bring about what has apparently been politically accepted by our governments.

"The focus on primary care is one of the changes in nursing practice. It is clear that in some situations drastic or revolutionary changes are needed in the criteria applied to health services; in others, at least radical reforms.

"Expanded nursing services are identified in the following areas: community health, pediatrics, adult health, family planning, family health, obstetrics and geriatrics.

"Among the most important implications of the extended role of nurses are the following: training in primary care of community members and nursing auxiliaries, coordination and integration in manpower planning and use of manpower resources for the health sector, new concepts of nursing legislation.

"To sum up, we will have greater possibilities to resolve the legal implications of the adoption by nurses of new functions, and the training of nursing auxiliaries, community members and other kinds of workers, to the degree that the nursing profession takes the initiative in opening dialogue with other professionals in the health field, with politicians and government authorities in order to obtain the legal support that, at least in Latin America and the Caribbean, has been expressed by the Ministers of Health.

"The nursing profession as a whole needs to be conscious of these changes and stimulated, through a large variety of means, in order to bring about the acceptance of radical changes. This requires a concentrated effort on the part of all nurses to further the introduction of new types of nursing services, in institutions as well as in the community. The profession must be aware of the need to carry out innovative or emerging programs and participate actively in them.

To face sudden deprivation of your voice is to face possible isolation from the rest of the human race. Nurses who understand the significance of this threat can aid immeasurably in restoring the confidence of the laryngectomee in his ability to maintain normal relationships with the people around him. Their careful pre-operative teaching, matter-of-fact acceptance of his loss and thoughtful attention to his immediate communication needs at this critical time can provide the foundation for successful re-adjustment later. To help you help the patient who will be undergoing a laryngectomy, we offer this teaching aid.

Laryngectomee Leaflet

Deborah Vandewater

This brochure has been prepared especially for persons like yourself who are about to undergo surgical treatment for cancer of the larynx. It is intended to provide a simple explanation of the procedure involved and to answer some of the questions that you may have about the effect of this operation on your present lifestyle.

Right now, you may be feeling any one of a number of very understandable emotions — fear, panic, depression, denial, anger or self-pity. No one in your situation has ever found it easy to get used to the idea that they are about to lose their power of "normal speech." On the other hand, as one laryngectomee has expressed it, the frustrations of learning to live without being able to whistle, to sing, to laugh aloud or even to speak in the accustomed way, can be largely offset by renewed appreciation for the gift of life. Cancer of the larynx is one of the most curable of cancers. The operation itself is relatively painless and, given time, practice and sufficient incentive, the laryngectomee *can* develop a "second voice."

A glossary of common terms

Laryngectomy is the name of the surgery involving removal of all or a portion of the larynx. The larynx is the organ of voice or the voicebox, and forms the Adam's Apple in your neck. There are two major types of laryngectomy surgery depending upon how much of the larynx is removed:

- *total* — where all of the larynx, including the Adam's Apple and the upper end of the trachea or windpipe (see diagram) are removed. You will not be able to use your natural voice again.
- *hemi, partial, supra-glottic, fronto-lateral* — where varying portions of the larynx are removed depending upon the extent of the spread of the disease. You will retain some of your voice after surgery although it may sound different — i.e. lower and raspy.

Tracheostomy or Tracheotomy is the name of the operation where a hole is made in your throat just below the Adam's Apple, for the purpose of breathing. The windpipe, which connected the mouth and nose to the lungs, and which you breathed through, is now brought out through this hole and sewn in place. A metal or plastic tube, consisting of an outer, permanent tube and an inner, removable tube, is usually placed in the hole to keep it open. It is through this hollow tube that you will now breathe. Again, there are two types of tracheostomies:

- *permanent* — where the hole will remain in your neck forever, because the surgery removed all of the larynx and closed off the windpipe.
- *temporary* — where the surgery removed only a portion of the voicebox and left the windpipe intact. The hole is made to ensure that you will be able to breathe while your neck is healing. It will be allowed to close over and to heal when the doctor is sure that you can breathe normally again through your mouth and nose.

Stoma or Tracheostoma: is the name for an artifically created opening — in this instance the name given to the hole in your neck that you will breathe through .... "the breathing hole."

Stoma Care is the name given to the care of the stoma and the tracheostomy tubes. Immediately after surgery, this care will be provided by the nurse. Later on, as you recover from your operation, you will be taught how to do it yourself. Stoma care involves frequent removal of the inner of the two tubes from the stoma to clean it of mucus and dried secretions, and then replacing it in the hole. The stoma and tubes must be carefully maintained to ensure a clear airway.

- A tracheostomy tube may not always be required. After the skin around the stoma is healed — i.e. is no longer red and raw after the surgery, and the hole can stay open by itself — the decision is often made that the tubes are not required or are only required at night to ensure an adequate airway when sleeping.
- There are a number of commercial products on the market that are designed to serve as a protective shield for the stoma. These stoma guards may be made of moulded plastic, crocheted nylon or cotton or gauze with aluminum frames. Many patients wear a metal screen attached to a knitted bib that covers the stoma and also serves to provide increased humidity. You will want to exercise your ingenuity in choosing clothing to camouflage the stoma or shield. Men may choose ascots, turtle-necked sweaters or shirts with neckties. For women there are high-necked blouses and sweaters, a large necklace or scarf. These give you a psychological lift as well as making you look nice and allowing you to breathe.
- The edges of the stoma are very sensitive to sunburn and to dryness. It is therefore important to protect this area from the elements. In the sun, a sunhat can shade the face and neck and protective lotion can be applied to the edges of the stoma. Make sure this lotion is water soluble so that if some of it gets into the trachea it will not block the windpipe and make it difficult to breathe.

After Surgery As you recover from your surgery, you will discover that certain adjustments must be made in your lifestyle. This will mean changing some old habits, relearning ways to do things, losing some old skills and gaining new ones.

The major change after surgery will, of course, be the loss of your voice. If the doctor removed only a portion of your voicebox, (as in hemi-laryngectomy), you will regain some of your voice although you may find that it is lower and deeper than before surgery. If the doctor removed all of your larynx, you will never again have your previous voice, but *it is important to remember that you will be able to learn to speak another way....to develop a "second voice."* Once the muscles and membranes are healed and no longer

tender, you will be able to begin speech therapy with a specially trained therapist or speech pathologist. This person will be able to show you how to use your old speech habits and skills, substituting other structures for the ones that are missing, and in this way, to develop a new voice. (Ask your nurse about these people.)

An alternative to esophageal speech is the use of one of a variety of voice machines (electrical or mechanical) which when placed against your throat send off vibrations which allow you a form of speech. All of this will be explained to you by the therapist.

Probably you will experience varying degrees of fatigue or tiredness after your surgery. This may be due to a combination of factors: the type of anesthetic that was used to put you to sleep during the operation and how it was given; how you reacted to the drug (your age and the size of your body); the extent of your surgery; and, perhaps, how well you were before the operation.

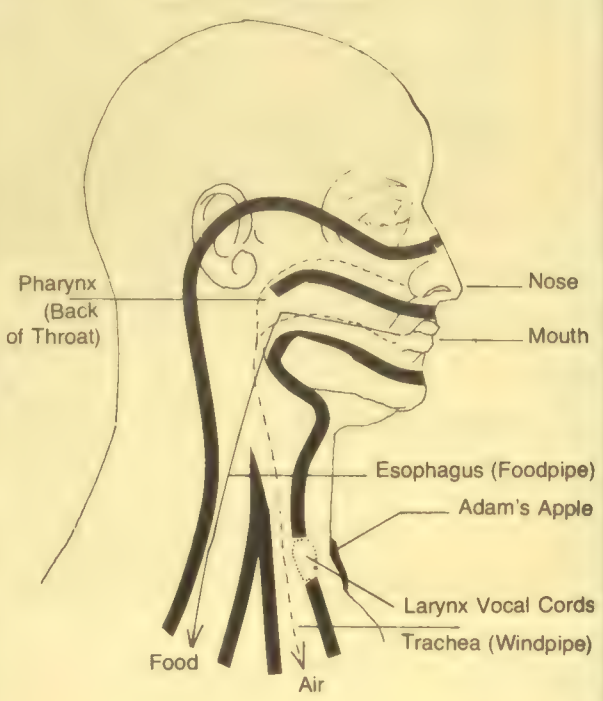
Because your surgery is quite extensive, you will be given a general anesthetic which will keep you asleep until the operation is completed. Usually patients wake up one to two hours after the surgery although you may continue to feel drowsy for a little while after that.

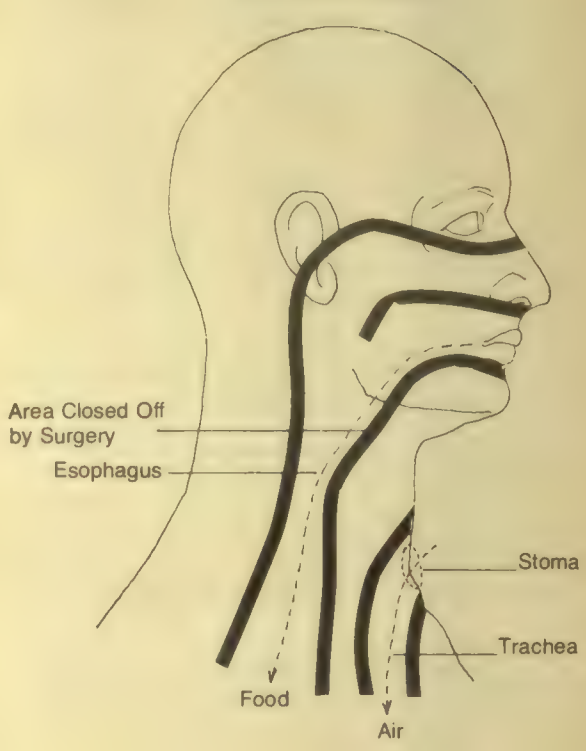
Whether you wake up in the same room that you were in before your operation, or in an Intensive Care Unit with special nursing care, the nurses will make sure that they provide you with some means of communication. Most often, this will be a pencil or pen and paper but it could also be a child's "magic" slate from which the writing can be erased by lifting the top page. Some patients and their families devise codes for tapping messages.

Within forty-eight hours of surgery, with the aid of the nurses, you will be able to get up into a chair, and then to begin walking. Barring complications you should be able to go home within ten to fourteen days after your operation.

There are other losses connected with the removal of your voicebox and the creation of a tracheostomy. For example, you will no longer be able to laugh, gargle, sing, blow out of your nose or mouth, or whistle. The loss of these activities may be very hard to adjust to but you can still smile and with the aid of your new voice you will soon be able to communicate effectively. You can no longer go swimming as before as you would get water in your stoma. Also, you must be careful when taking a shower or bath ... hold a towel between your teeth while you shower and let one end of it cover the stoma, or cup your hand over it.

You won't be able to force air from your lungs through your mouth or nose, or vice versa anymore because your windpipe is no longer connected to these openings. This will end your ability to smell through your nose. For some patients this means permanent loss of their sense of smell; for others, the ability to smell may be restricted to strong pungent odors, or may only be temporarily lost. The degree of loss of taste that you will





experience is closely related to loss of your sense of smell. Studies indicate that most patients appear to recover some, if not all, of their sense of taste, or at least tastes associated with sweets or acids. This may take up to eighteen months. A problem associated with the loss of taste and smell may be weight gain. A weight control diet may have to be instituted in the period after your surgery.

Because you can no longer blow your nose you must now clean out your nostrils with a damp cloth. Also, because of your newly shortened windpipe there is less time for the air inhaled to be warmed, moistened, and cleaned. Consequently laryngectomees are more prone to colds. This possibility can be minimized by ensuring humidified air wherever possible. Bath time can provide excellent humidification. This will also prevent thickening of mucus and secretions which would make it more difficult to cough out of the stoma.

Before your surgery you were able to lift heavy objects or bear down to move your bowels by holding your breath. What happened was that the larynx closed off the entrance to the windpipe and thus prevented the escape of air from the lungs. After surgery this method will no longer be possible. Instead you can learn to use the muscles of your arms, legs, back and stomach to lift, and to prevent constipation by including more roughage in your diet (lettuce, celery, bran, meat) or by using gentle laxatives with your doctor's permission.

There are several problems associated with the digestive system to which you may or may not be subject. If you are an esophageal speaker,(i.e. if you talk by swallowing air into the esophagus or the back of your throat) you may find that you swallow air into your stomach causing gas. This may be dispelled by the use of antacids.

A more difficult problem to manage is the regurgitation of stomach acids which may cause throat irritation and which can mimic a heart attack: burning, chest constriction, a feeling of fullness. To prevent such attacks at night, sleep with your head elevated on a pillow keeping your stomach lower than your throat.

A word of caution

- Men should take extra care during shaving so as not to cut the edges of the stoma as the nerve endings in the skin are deadened for approximately six months after surgery. Don't let the lather get too wet as it might drip into your stoma and cause coughing.
- Don't take any medications without your doctor's permission as many tend to dry out the stoma. "Over-the-counter" drugs such as decongestants for colds, and antihistamines for allergies must be checked out in advance. In fact, drinking even a few ounces of alcohol may cause the same problem.
- If you have had radical neck surgery as well as a laryngectomy and tracheostomy, you may find that the movement of your arm on the operative side is limited when lifting your elbow above your shoulder. But there are exercises (for example, walking your fingers up a wall, or moving your arm in a circle above your head) which will improve the degree to which you will be able to lift it.
- During the early period after discharge from hospital and even after he is home for a while, the laryngectomee tends to breathe heavily or to "blow air" out of his stoma. The stoma is also apt to have a constant ring of mucus around it and may be odorous. These occurrences may be noticeable to both the laryngectomee and others, especially during sexual intercourse as breathing is important in sexual response and orgasm. To limit these irritations the stoma may be covered with a scarf or bib, and perfume or shaving lotion can be worn. It has been observed that with laryngectomees who learn esophageal speech, the heavy neck breathing will become much more controlled.
- One of the very common fears among neck breathers concerns their ability to breathe under the bedcovers at night and the possibility of suffocating. It is a very genuine fear but one that is easily set to rest: your body can sense a lack of air and then turns automatically, thus preventing you from smothering.

Conclusion

This leaflet is intended to provide only an overview as to some of the experiences you may have during your hospital stay and after discharge , as well as the ways in which laryngectomy surgery may affect your lifestyle. Questions may arise as you read this leaflet. If so, make sure you ask your nurse or doctor. As your rehabilitaiton progresses, you will have other questions. One of the most helpful steps you can take is to contact a "Lost Cord" club near you. There are now half a dozen "Lost Cord" or "New Voice" clubs scattered across Canada. A list of names and addresses of local presidents follows. Club members, who are all laryngectomees, are dedicated to assisting in the total rehabilitation of their fellow laryngectomees. They are eager to help you as they themselves were helped.

Malignant neoplasm of the larynx

	Incidence		Surgery	
	1968	1973	1968	1973
Males	770	1540	210	250
Females	116	255	36	86
Total	886	1795	246	336

Source: Statistics Canada. *Hospital morbidity: Canadian diagnostic list, 1969-1973.* Ottawa, Information Canada, 1972-1976. (Cat. no. 82-209); and Statistics Canada. *Surgical procedures and treatments, 1969-1971.* Ottawa, Information Canada, 1972-1974. (Cat. no. 82-208).

Lost Cord Clubs (Canada)
Victoria: Seth Halton, 747 Falkland Road, B.C. V8S 4L9
Vancouver: David Jock, 25523 Robertson Crescent, R.R. 4, Aldergrove, B.C.
Calgary: Gertrude Paller, 3212 Richmond Road S.W., No. 232, Calgary, Alberta, T3E 4N4.
Winnipeg: Stanley Luby, 529 Doucet St., Winnipeg, Man., R2J 0M6.
Toronto: John Hardy, 2800 Bloor St. W., Apt. 303, Etobicoke, Ont.
Montreal: Pierre C. LeCault, 7085 DeLanaudiere, No. 1, Montreal, P.Q. H2E IYI.

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Deborah Vandewater, R.N. B.N., *received her Bachelor of Nursing from Dalhousie University in Halifax, N.S., in 1975 and is presently enrolled in the Master of Nursing Program at the same university. "A Laryngectomee Leaflet" was written in partial fulfillment of medical-surgical course requirements and is an offshoot of the topic she is currently researching for her thesis. Deborah writes: "Over the months of research since September of 1976 I have become very interested in what types of pre-operative preparation, education-wise, the patient who is to have laryngectomy surgery has made available to him. I have found large areas lacking such appropriate tools which could help the patient ....hence the Leaflet."*

Idea Exchange

Well Woman and Health Awareness Clinic

Yarmouth Regional Hospital is a 159-bed general hospital in Yarmouth, Nova Scotia. Since January of this year, a health promotion clinic has been in operation at the hospital's Diagnostic Complex to meet the health needs of women in the area. Since this time, the clinic has seen many patients, young and old, of varied backgrounds. Here, the author describes the aims, approaches and initial experiences of the Well Woman and Health Awareness Clinic.

Glenda Doucet

The purpose of our project is to use a systems approach in order to assess the need for services that are not presently provided by the health delivery or social welfare agencies in Nova Scotia. Groups of women identified certain gaps in the area of maintaining health and preventing disease — early detection and diagnosis of cancer or other diseases affecting the female reproductive organs and the absence of health counseling were major concerns.

With grants from Planned Parenthood of Nova Scotia and the Secretary of State, a pilot demonstration project was established in the Diagnostic Complex of the Yarmouth Regional Hospital. Three nurses organized the Well Woman and Health Awareness Clinic and are now involved in its operation. The clinic has only two full-time paid employees: a nurse, who is the coordinator of the project, and a secretary-receptionist who has six year's experience as a medical receptionist. Both employees are bilingual — a necessity for effective service in this area of Nova Scotia.

Volunteers include six women physicians, ten registered nurses, a dietitian, and those from the community who have special skills needed at the clinic from time to time. Volunteers and staff work together and an interdisciplinary approach is maintained for the ten services provided by the clinic.

From screening to baby-sitting...

The services provided by our clinic attempt to fill a gap, to make available a place where people can come for testing, counseling, health teaching and support. So far, these services include the following:

- *Screening*

Medical and cancer screening is one of the functions of our clinic. Initially patients are seen by a nurse who takes patient histories and blood pressure readings, tests urine for glucose and ketones and does fingerprick hemoglobin testing. The patient then sees a woman doctor for a breast examination, pap test, bimanual pelvic examination, and rectal examination.

This clinic is mobile; it is held in the Clare District at the Women's Centre — Les Femmes Acadiennes de Clare — three times a month. Clare District is a predominantly French-speaking area 45 miles away from Yarmouth. So far, 17 per cent of the patients seen at the clinic have been been referred for diagnostic tests. Twenty-two per cent of all clinic patients were diagnosed as having a problem that needed medical attention.

- *Preparing Children for Hospitalization*

In order to help young children cope with separation anxiety when they are admitted to hospital, a service for preparing children for hospitalization was organized at the clinic. A nurse talks to parents and children about admission procedures and hospital routines and helps the parents to establish realistic long- and short-term goals for the child scheduled for surgery. Depending on the child's age, play therapy with a Fisher-Price Hospital* may be initiated by the nurse.

The family is then taken on a tour of the hospital — to see the lab, x-ray department, operating room area, children's ward, and kitchen. The staff of the pediatric ward has been telling us that prepared children adapt to the hospital setting more easily, are less

* *Fisher-Price Hospital is a registered trademark of Fisher-Price Toys.*

frightened and generally much happier with their hospital stay.

- *Family Planning*

The clinic offers family planning counseling to individuals or to groups. Teaching in this area includes evaluation of the risk of pregnancy to the individual, explanation of basic anatomy and physiology, and discussion of different birth control methods.

- *Sex Education in Schools*

According to Statistics Canada, Nova Scotia has one of the highest illegitimate birth rates in Canada. Yarmouth, at 22 per cent, has one of the highest rates in Nova Scotia. The Well Woman and Health Awareness Clinic and its supporters decided to use teaching in the schools in an attempt to alter this situation.

The School Board has agreed that some of the volunteer professional staff be allowed to teach sex education in the schools, beginning in September, 1977. The curriculum will include basic anatomy of male and female reproductive organs, conception, pregnancy, birth, contraception, sex roles, venereal disease, drugs, homosexuality, and marriage. A successful sex education class for parents has been held in order to help them to accept the idea of sex education in the schools and to let them know what we will be teaching their children.

- *Growth and Development*

In order to help parents to understand and fulfill their role, we teach them about general growth and development and effective child rearing practices. We are very fortunate in having a local pediatrician who gives bimonthly sessions on these topics.

- *Teenage Counseling*

Counseling is also available to teenagers at the clinic. This service is provided by a nurse who talks to young people about major problems and concerns of everyday living.

- *Nutrition Counseling*

A volunteer nutritionist offers nutrition counseling to patients referred to the service. She interviews each patient, obtains a full dietary history and a nutrition recall. Most nutrition counseling focuses on weight reduction or help with special diets. Follow-up visits are arranged as necessary. If patients requiring nutrition counseling feel that they live too far away for easy access to the clinic, the clinic's nurse makes referrals to the public health nutritionist visiting their area.

- *Breast-Feeding*

Breast-feeding classes have been established at the clinic to encourage soon-to-be mothers to breast-feed their babies. This educational service is undertaken by the nurse coordinator and a number of volunteer mothers and nurse-mothers who have breast-fed their babies. The classes cover basic anatomy and physiology of the breast and breast-feeding, preparation and care of the breasts and nipples, positions and procedures for breast-feeding, the manual expression and freezing of breast milk, drugs that affect lactation, and possible problems, including sore and cracked nipples and engorgement. The public health nutritionist talks to expectant mothers at the clinic about their own nutrition and about weaning the baby, and introduction of solid foods to the child.

- *Ostomy Care*

The South West Nova Ostomy Chapter operates within the clinic to provide emotional and psychological counseling and skin care teaching to ostomates. A nurse makes home visits, helps patients prepare for barium enemas, and accompanies patients to the x-ray department. The nurse responsible for these services will be taking enterostomal therapy training in Cleveland, Ohio in August of this year.

- *Baby-Sitting*

The clinic offers baby-sitting services to anyone using the hospital facilities. A charge of 50 cents per hour for each family covers the cost of juice and cookies for the children. Volunteer baby-sitters look after the children.

Four Months

We have also developed a questionnaire to assess patients' knowledge of and experiences with the menopausal period. This questionnaire is now at the pre-testing level.

The Well Woman and Health Awareness Clinic has seen 744 patients in the first four months of its operation. Our patients have ranged in age from seventeen to eighty. They are women from high and low socioeconomic groups, from varied cultual backgrounds and from as far as 75 miles away from Yarmouth.

Glenda C. Doucet, *R.N., B.N., the author of this month's Idea Exchange, graduated three years ago from Dalhousie University School of Nursing in Halifax, N.S. Between graduation and a job first as one of the organizers and then as coordinator of the Well Woman and Health Awareness Clinic, she worked as a nurse at a center for children with learning problems. Of her work at the clinic, she says: "My role is a dual one, including both administration and nursing service. I administer the program under the guidance of the board of directors. Nursing tasks include: taking patient histories; operating the mobile clinics; preparing children for hospitalization; family planning counseling; coordinating classes in breast-feeding and teaching some sessions."*

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Ethics and the Law in Practice

Manuel Escott



Two areas of major concern to nurses — ethics and the law — are examined in depth in a program just completed by Ontario's Nursing Education Media Project (NEMP).

The series of 18 videotaped programs with briefs for teacher guidance was produced in response to a demand from NEMP's members, Ontario's 21 community colleges, the Registered Nurses Association of Ontario, and the College of Nurses of Ontario. Although the series is aimed primarily at student nurses, NEMP officials believe it will also be useful to all members of the health-care team.

Certainly the timing of the program couldn't be better: malpractice suits against hospitals and their staffs are mounting, and the volume and nature of those suits raise questions about the standard of nursing education and health care.

"Now more than ever it is the nurse's personal responsibility to be aware and informed," says Marilynne Seguin, NEMP's project coordinator. "She or he can no longer hide under the cloak of an institution for protection. The nurse must bear personal responsibility, personal liability."

The $40,000 program was produced in cooperation with another NEMP member, TV Ontario. Professional actors are used in each film and the scripts are based on real-life situations. The hospital dramatizations were filmed on a ward at Toronto's Orthopaedic and Arthritic Hospital. Consultants were Dr. Abbyann Lynch, a philosophy teacher at the University of Toronto and a former teacher of ethics at several nursing schools, and Dr.T. David Marshall, a physician-lawyer and an internationally known authority on medical-legal jurisprudence.

The law series covers topics such as consent, negligence, mental health, coroners' inquests and contractual relationships.

"Contractual relationships are important to examine because nurses are often held responsible for advice they've given given informally — say, to a neighbor whose child has been injured or is ill," explains Seguin.

Preceding the law series is a 68-minute videotape, "Charge: Incompetence, a Mock Hearing of the Discipline Committee of the College of Nurses of Ontario," that reenacts an actual hearing.

While the legal issues seem clear-cut, it is in the ethical field that the lines begin to blur. Ethical conduct is influenced to a large extent by upbringing, religious belief and personal prejudices. Can a nurse embittered by the experience of an alcoholic father, for example, treat an alcoholic patient objectively or will her efficiency be impaired by her prejudice?

Other facets examined in the ethics series, as stipulated in the International Code of Nurses, are: primary responsibility, competence and continual learning, environment, safety, consent, truth, confidentiality, and behavior control. No attempt is made to attribute blame or define right or wrong responses to a given situation. All the dramatizations and briefs are designed to encourage discussion and to explore the issues from many standpoints.

The ethics series corresponds directly to the problems confronting nurses in the working world. Nursing teachers will readily identify with some of the ethical dilemmas posed, and will be able to ask students: "What would you do in the same situation, and what are your responsibilities?"

For example, few senior nurses have been able to avoid the situation where a chronically ill patient who is receiving a drug placebo asks: "Why is the medicine not helping my pain?" How does she reply?

Or take the case of the terminally ill patient who refuses further treatment, although the health team thinks some new therapy will help. Does the team have an obligation to help change the patient's mind or to respect his wishes to avoid further suffering?

What clearly emerges from this series is a challenge to students to think about their own ethical positions before they confront an actual situation. Film producers hope that students will become more aware of the responsibility they will have to bear on the job, more aware of the importance of their decisions, more aware of the quality of life.

"All the issues raised in both the law and ethics series are of paramount importance to nurses," says Seguin. "Doctors are usually considered as making the larger ethical decisions, but nurses daily have to make many judgments of equal importance to the patient."

Nursing agencies in Ontario that are not NEMP members can obtain the series by contacting: *VIPS, Ontario Educational Communications Authority, Box 200, Station Q, Toronto, Ontario, M4T 2TI.*

Interested agencies outside the province should contact: *Marilynne Seguin, Project Coordinator, Nursing Education Media Project, Ontario Educational Communications Authority, 2180 Yonge Street, Toronto, Ontario, M4S 2CI.*

Books

Introduction to Bowel and Bladder Care by Sister Kenny Institute Staff, Sister Kenny Institute, Minneapolis, Minnesota, 1975, 35 pages.
Approximate price $2.90 Reviewed by Olive Simpson, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

This booklet is a much-needed contribution to the care of those persons suffering from the loss of bowel and bladder control. Preparing information such as this (applicable to all health professionals, and the client) is a difficult task. Diagrams and pictures are well used within the text.

The authors intend the manual to provide basic information on bowel and bladder function, along with a general guide in the development of care plans for those patients who do not have bowel and bladder control. To assist readers to better understand when the need for elimination is not being met, the writers have included a short description, with diagrams of the normal anatomy and physiology of the urinary and gastro-intestinal systems. Some pathology is included in the booklet (eg. neurological conditions which affect bowel and bladder control). Descriptive diagrams showing the effect of trauma to the brain and spinal cord are also incorporated in the text.

The development of bowel and bladder care plans are described with measures which may be used in assisting the individual to work toward some degree of voluntary bowel and bladder control. A small section is included on external urinary appliances and protective clothing.

Appendix A explains the procedure for the insertion of a urinary catheter. Appendix B describes the collection of a sterile specimen of urine. The writers have added a short glossary for the lay person's benefit.

Library Update

Publications recently received in the Canadian Nurses Association Library are available *on loan* — with the exception of items marked **R** — to CNA members, schools of nursing, and other institutions. Items marked **R** include reference and archive material that does *not* go out on loan. Theses, also **R**, are on Reserve and go out on Interlibrary Loan only.

Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

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Registered Nurses — Licensed Practical Nurses required immediately for new 300-bed extended care hospital in Vancouver area. Must qualify for B.C. registration. Write: Co-ordinator of Patient Services, Queen's Park Hospital, 315 McBride Boulevard, New Westminster, British Columbia, V3L 5E8.

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Registered Nurses — required immediately for a 340-bed accredited hospital in the Central Interior of B.C. Registered Nurses interested in nursing positions at the Prince George Regional Hospital are invited to make inquiries to: Director of Personnel Services, Prince George Regional Hospital, 2000 - 15th Avenue, Prince George, British Columbia, V2M 1S2.

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Please apply to:

Administrator
Mayerthorpe General Hospital
Mayerthorpe, Alberta
T0E 1N0

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8th Floor, Marsland Centre
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N5A 2Y6

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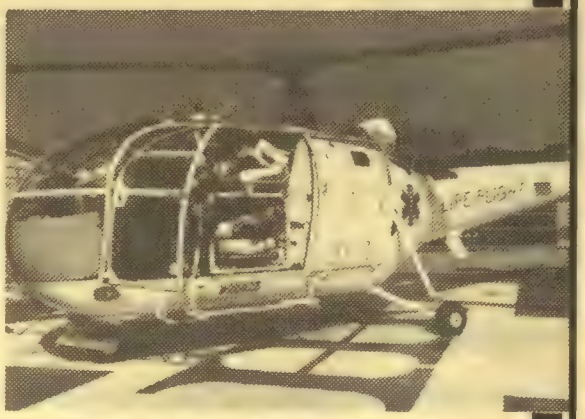
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Canadian Nurses Association
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Salary — negotiable

Please apply to:

The Administrator
Mills Memorial Hospital
4720 Haugland Avenue
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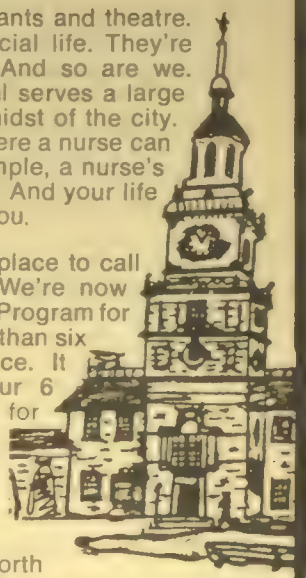
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Please forward complete resume to:

Personnel Director
St. Anthony's General Hospital
Box 240
The Pas, Manitoba
R9A 1K4
Telephone: 204-623-6431

ASSOCIATION OF REGISTERED NURSES OF NEWFOUNDLAND

Nursing Practice Advisor

Applications are invited for the position of Nursing Practice Advisor.

Qualifications:

- Degree in Nursing, preferably at the Master's level
- Registered, or eligible for registration, with the Association of Registered Nurses of Newfoundland
- Knowledgeable about the organization of the Nursing Profession
- Should be prepared and have experience in nursing practice, especially in the development and implementation of standards

Salary:

Negotiable, depending on qualifications and experience

All replies confidential

Applications to be forwarded to:

Executive Secretary
Association of Registered Nurses
of Newfoundland
P.O. Box 4185
St. John's, Newfoundland
A1C 6A1

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Salary: $1,089.00 — $1,219.00 per month
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On any of the above positions — please apply in writing with a complete resume:

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Saint John General Hospital
P.O. Box 2100
Saint John, New Brunswick
E2L 4L2

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1978

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Projects should be submitted for October 31, 1977.

Requests for information should be directed to:

International Health Services
Brooke Claxton Building
Tunney's Pasture
OTTAWA, Canada
K1A 0K9

Director of
Nursing: $21,306 — $26,943

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Please submit application by Sept. 7, 1977 to the Personnel Officer, Mental Health Centre, Penetanguishene, Ontario, L0K 1P0.

This position is open equally to men and women.

Ontario
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Children's Hospital of Eastern Ontario
Hôpital pour enfants de l'est de l'Ontario

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The Executive Director
Children's Hospital of Eastern Ontario
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K1H 8L1

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Medical Services Branch
Department of National Health and Welfare
Ottawa, Ontario K1A 0L3

Name

Address

City Prov.

Health and Welfare Canada / Santé et Bien-être social Canada

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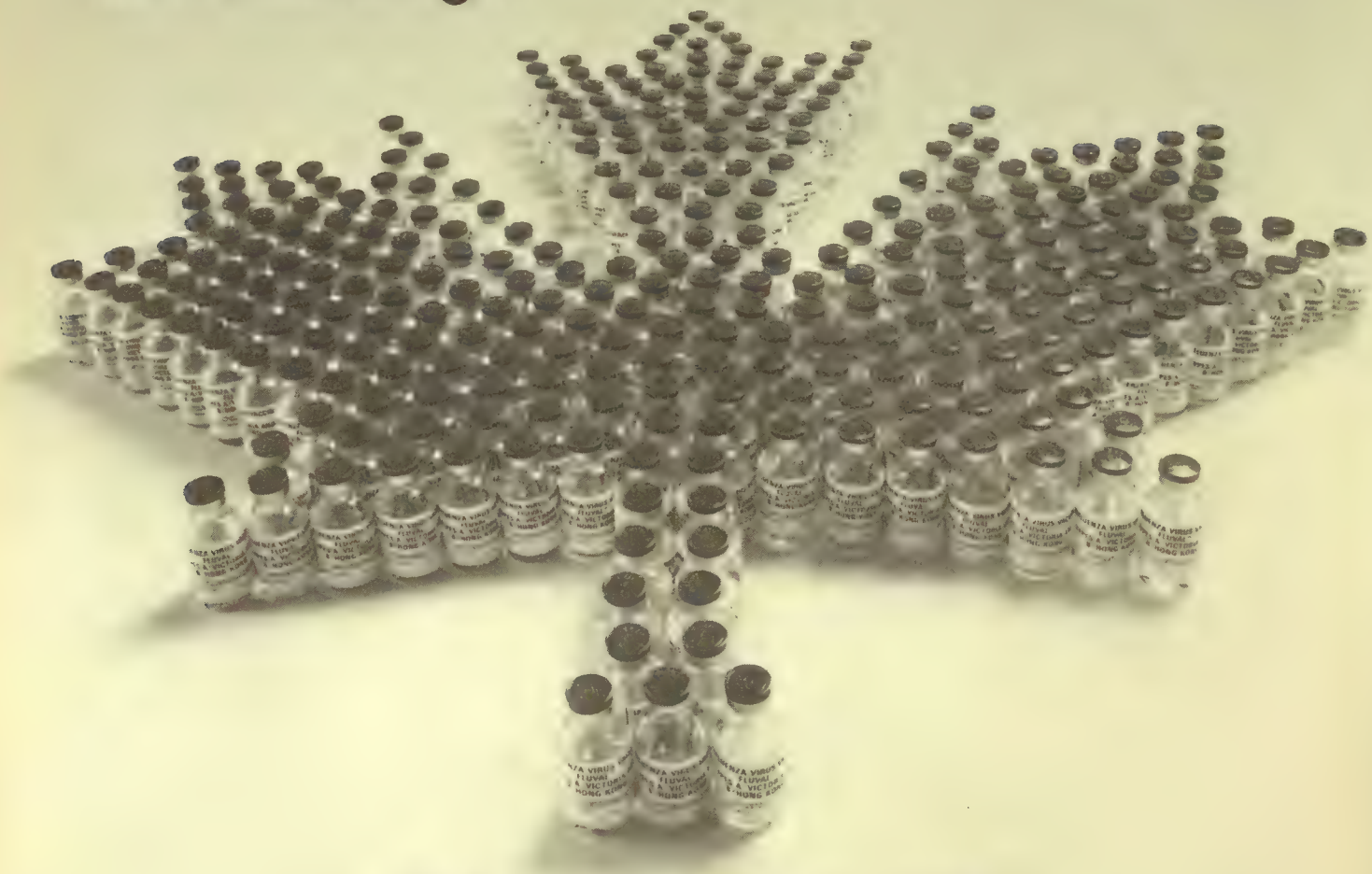
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the canadian nurse

September 1977

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the canadian nurse

September, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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The two smiling faces on our September cover belong to Jean Bates (right), nurse coordinator of the Tri-Hospital Diabetes Education Centre in Toronto, and to Jean Smith, a patient at the centre. For more on Tridec and on other aspects of patient care and education as they relate to diabetics of all ages, see this month's three-part feature that begins on page 14.
Cover photo courtesy of Tom Burns, Medical Photographer, Women's College Hospital, Toronto.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

ISSN 0008-4581

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Perspective

In this issue, CNJ reports on the results of its recent mail-in survey on how readers feel about working nights. We think the results are interesting — mostly because they represent some very frank and personal reactions to what is obviously an important aspect of the package that today is being called "quality of care".

Obviously, the hours that you work and the way that you feel during those hours have a lot to do with the way that you do your job. If you "walk a metabolic tightrope" that makes working nights a miserable part of your nursing career, what can you do about it? What can hospital administrators do about it?

Round-the-clock nursing care means exactly that. But what can we do to make sure that the quality of that care is as good at four o'clock in the morning as it is at two o'clock in the afternoon?

When we asked you to tell us how you feel about working nights, we did not do this in anticipation of making a major scientific breakthrough in this area. Our resources placed definite limitations on the kind of data and conclusions that we could come up with.

Our major recommendation is simply a plea for a more informed and rational approach to the fundamental question of "who shall watch and who shall sleep."

This summer, a dispute in Nova Scotia made it clear that the effects of 12 hour shift have not yet been effectively evaluated. The dispute arose when administrators at a Halifax hospital decided to eliminate 12 hour shifts on at least one unit of their hospital on the grounds that they caused fatigue and inferior patient care.

But if administrators failed to substantiate their arguments that 12 hours shifts were too hard on their employees, the Nova Scotia nurses' union was no further ahead. Tom Patterson of the Nurses' Staff Association of Nova Scotia said, "Although hospital administrators had no solid ground for ending 12 hour shift, we had nothing to support our position in favour of the 12 hour shift. To my knowledge the effects of 12 hour shift simply haven't been studied enough."

The dispute ended when the hospital decided to continue the 12 hour shift with an important stipulation — that committees be established to evaluate the effectiveness of 12 hour shift and its special problems.

In the light of today's economic realities and the stress that every nurse is under to perform at optimum levels throughout each shift — whether that shift is twelve or eight hours, day, evening or night — isn't it about time that nurses everywhere supported a more informed and analytical approach to this very important question?

—M.A.H.



"Now tell me, just how long have you been feeling rejected?"

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Input

Fetal Monitoring

As the author of the article advocating fetal monitoring for all women in labor (Fetal Monitoring, Why Bother? March, 1977), I feel I must reply to several of the statements in Elaine Carty's letter (Input, July, 1977).

First of all, Carty cites a study which compared the outcomes in labors which were monitored electronically with those which were monitored through auscultation of the fetal heart every 15 minutes in the first stage and every 5 minutes in the second stage of labor (The Evaluation of Continuous Fetal Heart Rate Monitoring in High Risk Pregnancy, Haverkamp, A., et al., *Am. J. Obstet. Gynecol.*, June 1, 1976). It is true that the authors found no significant difference in perinatal mortality or morbidity; however, they admit to difficulties in deciding how to evaluate morbidity. They followed the hospital course of each infant for 72 hours after birth; morbidity was determined according to the following criteria: need for neonatal intensive care, seizures, lethargy, diarrhea, poor feeding, jaundice, and antibiotic treatment for documented sepsis. This was obviously not a longitudinal study. What about long-term problems (i.e. cerebral palsy, mental retardation, visual, auditory, and perceptual difficulties) which may not become apparent until much later in the child's life? There are other limitations to this study; these are cited by the authors themselves and by the distinguished experts who critique it in the pages immediately following the article.

Secondly, while I agree with Carty that lying on one's back is a bad way to labor (for both maternal and fetal reasons), I must point out that:

- monitoring need not interfere with positioning (even if the patient is being indirectly monitored, the nurse simply adjusts the belts according to the position the patient takes), and
- the woman in the photographs in my article is lying with the head of her bed elevated 30°.

Thirdly, although I have worked in three major metropolitan delivery suites (each with over 2000 deliveries per year), I have never seen nurses auscultating fetal hearts every 15 minutes on a routine basis. To do so would require a much higher nurse-patient ratio than hospital budgets will permit. Also, in order for a nurse to auscultate a fetal heart, the patient must lie on her back; this can produce fetal hypoxia and again, it is a poor way to labor. I agree wholeheartedly with the importance of the nurse's physical and emotional support through labor. The monitor should never be used as an excuse to decrease the amount and quality of nursing care; it is meant to improve care, not substitute for it.

Fourth, there is no basis for stating that fetal monitoring increases the level of maternal anxiety, let alone the incidence of fetal distress. Numerous authors, including Dr. Morton Stanchever (who critiqued this study) state that patients are reassured by the presence of the fetal monitor, probably because they realize that the baby's progress is being carefully watched. In my experience, patients and their husbands have been pleased to see their baby's heartbeat on the screen. It is the patient's right to have *all* unfamiliar procedures (including shave preps and enemas, as well as fetal monitoring) explained to her, so that she understands what is being done and the reasons for it. Furthermore, there is no need for the patient to have to listen to the sound of the fetal heart — electronic monitors have volume controls which can be shut off without interfering with the transmission of the fetal heart pattern onto the recording paper.

Finally, I am concerned that the fetal monitor is becoming a scapegoat. There is a great deal wrong with so-called "modern obstetrical care." Consumers and nurses alike are worried about depersonalization of care, lack of patient participation in decision-making during the childbearing cycle, overuse of oxytocics and anesthetics, and other interferences with the normal process of labor. The fetal monitor is being viewed as one more unnecessary, interfering gadget. As an advocate of the rights of the fetus to the best possible start in life, I hope that we can keep and improve upon what is good about modern obstetrical care (including fetal monitoring, prenatal education, and husband participation during labor and delivery) while working to eliminate the bad.

— Ellen Hodnett, Lecturer, University of Toronto, Faculty of Nursing.

She, shis and shim

Language develops in a rational pattern to express what the human mind has to communicate. Language is slippery and intractable because it must not only serve man's expression of ideas, but it must assure the universal comprehensibility of the means used. One cannot apply logic to language and draw parallelisms. For example, if the masculine pronouns are he, his and him; one cannot say the feminine pronouns are she, shis and shim. Similarly, if the plural of mouse is mice, the plural of house is not hice. Words also have a variety of meanings because they may be used to express a variety of actions, states or concepts. Raise and raze are pronounced the same but have opposite meanings.

There is also a tendency to confuse sex with gender. They are not interchangeable terms. Many times they coincide but not always. For example, in Latin the word for sailor is *nauta,* feminine gender. In German, neuter gender denotes a child, das Kind, a girl, das Madchen, and a horse, das Pferd! Similarly in English, reference pronouns need not follow sex. In French, the gender of the pronoun is determined by the gender of the noun, for example sa mère means his or her mother.

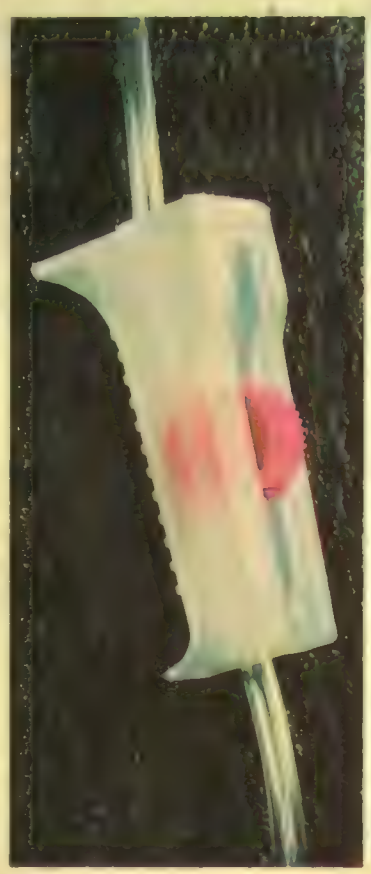
Of late there have been attempts to impose on language violations and falsifications of its linguistic patterns and order. A case in point is the neologism "Chairperson" to distinguish the sex of the presider. This is an absolute misreading of the term. Chairman is a combination of two words: *chair* and *man.*

To use *chair* is not so much a word as a figure of speech called metonymy. This is where an associated word is used to express an attribute. For example, we say "crown" to mean "state", the "bench" to mean the law, and we use "the chair" to mean authority, because the presider at a meeting sat on a platform or dais. Similarly, the term man (in chairman) does not mean a male, but the wielder, from the old English verb MANNIAN, to handle or wield. The origin probably stems form the Latin *manus*. Therefore, the term chairman means "the wielder of authority". To say chairperson is to indulge in meaningless expression. Proof of the matter is the term used to denote a very able handling of a meeting, good chairmanship. In like vein, oars are manned, whether they are operated by men or women. The wielders are oarsmen, and a *good* performance is good oarsmanship. Oarpersonship would be both meaningless and absurb.

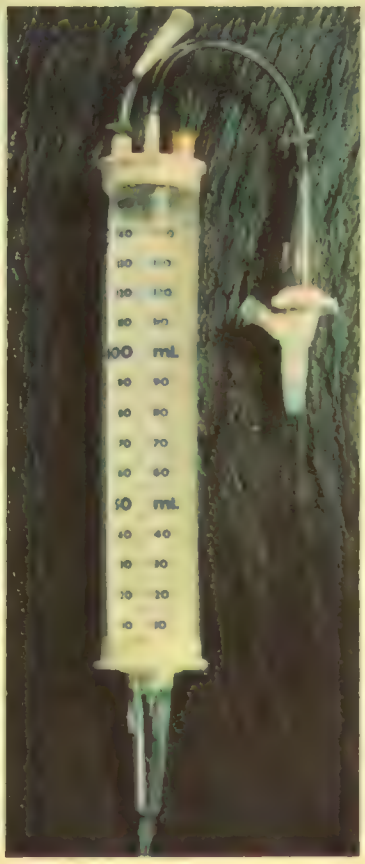
It is disturbing to attend national or international meetings presided over by educated women who call themselves chairpersons. According to *Webster*, among other meanings a person is "a human being as distinguished from an animal or thing", or "an inferior human being". Compared to that definition wouldn't women wish to be chairmen, wielders of authority?

—Ella MacLeod, director, Public Health Nursing Division, Department of Health, PEI.

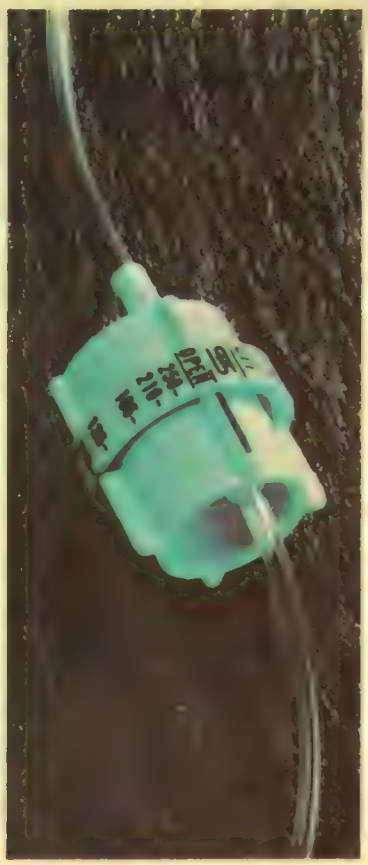
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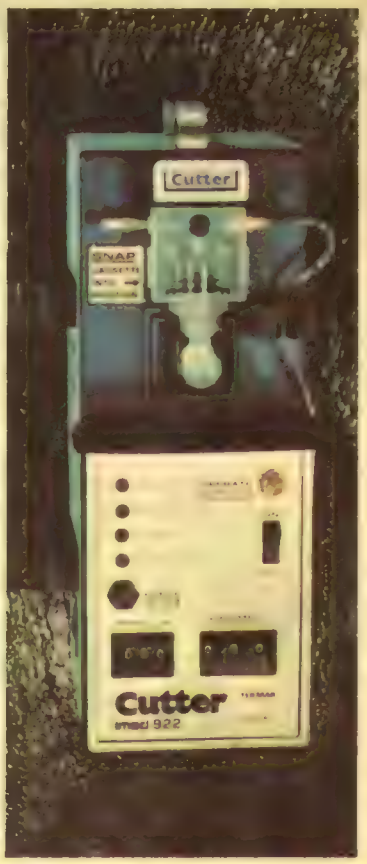
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News

Better working conditions for nurses

A new Convention aimed at creating better working conditions for nurses has been adopted by the International Labour Organisation.

The Convention calls for national policies, within general health programs, designed "to provide the quantity and quality of nursing care necessary for attaining the highest possible level of health for the population."

In particular, the Convention states that ratifying countries must take measures to provide nursing personnel "with education and training appropriate to the exercise of their functions and both employment and working conditions which are likely to attract people to the profession and keep them in it."

The Convention was adopted by government, employer and worker delegates from 126 ILO member countries. The delegates were participating in the 63rd Session of the International Labour Conference in Geneva, Switzerland, last June.

Discussion at last year's session concluded with agreement for a Recommendation only. But a workers' proposal at this year's session got enough support from government delegates for the adoption of a Convention — a legal agreement designed to enable nurses "to enjoy a status corresponding to their role in the field of health."

Ratification of the international agreement would enable nurses to make a larger contribution to health care in their countries.

Nurses, known traditionally for their patience and sense of duty, have recently gone on strike in several countries in defence of their occupational, moral and economic interests.

Drafted in collaboration with the World Health Organization, the ILO Convention will try to ease the crisis in the profession with guidelines for better pay, shorter working hours and job satisfaction.

The Convention calls for participation of nursing personnel in the planning of nursing services, and for consultation with nurses on decisions concerning them.

"Settlement of disputes concerning terms and conditions of employment should be sought through negotiation between employers' and workers' organizations. This can be accomplished only through independent and impartial machinery such as mediation, conciliation and voluntary arbitration."

The Convention states nursing personnel should enjoy conditions which are, at the very least, equivalent to those of other workers in their country. This includes hours of work, weekly rest, paid annual holiday, educational leave, maternity leave, sick leave and social security.

Delegates to this year's session also adopted a Recommendation concerning employment and conditions of work and life of nursing personnel. The Recommendation covers a wide range of problems that confront nurses in our modern health care system; education and training, career development, remuneration, working time and rest periods, occupational health protection, social security and international co-operation. "Only through co-ordinated action in each of these areas can conditions of nursing personnel be improved in a lasting way."

Of special interest is the provision in the Recommendation by which nurses would be able "to claim exemption from performing specific duties, without being penalized, where performance would conflict with their religious, moral or ethical convictions." This is the first time such a "conscience clause" has appeared in an ILO agreement.

The Recommendation also states that:

- National legislation "should prescribe the basic requirements regarding nursing education and training" and provide for its supervision.
- Continuing education and training, both at the workplace and outside, should be an integral part of the training program.
- National legislation should "limit the practice of the profession to duly authorized persons."
- Nurses should be able to participate in any decisions which involve either their profession or national health policy in general.
- Normal daily hours of work should be continuous and not exceed eight hours. In any case, the working day, including overtime, should not exceed 12 hours.
- The weekly rest period should, in no case, be less than 36 uninterrupted hours.

A conference for supervisors

Twenty-two evening and night supervisors from eight hospitals in the Sydney, N.S. area met recently for the first time to discuss their common problems and share their ideas and experiences.

Members at the Sydney conference talked about several problems that hold high priority for them, including improvement of communication among medical staff administration and nursing so that policies are clear and ensuring the proper use of "Emergency" beds.

At the end of the one-day meeting, a number of recommendations were made by those attending. Among these were:

- that supervisors continue to meet as a group every four months to continue discussions;
- that they elect an executive and appoint a representative from each hospital;
- that as a long-term goal they plan to organize all evening and night supervisors on a provincial basis;
- that they arrange annual or semiannual conferences to include supervisors, administrators and directors of nursing;
- that they organize a Medical-Nursing Liaison Committee;
- that the Coordinator prepare a draft position paper (for review by participants) which would emphasize the need for concise written policies in hospitals.

The meeting of supervisors was attended by Gladys Smith, president of the Registered Nurses Association of Nova Scotia, and Jean MacLean, Nursing Service Consultant, RNANS.

NBARN holds 61st annual meeting

This year's annual meeting of the New Brunswick Association of Registered Nurses attracted approximately 250 nurses and nursing students from around the province. NBARN's outgoing president **Simone Cormier** addressed the opening session of the two-and-one-half day meeting held in early June.

Speaking about dissatisfactions in nursing today, Cormier said that more and more nurses are questioning the future of health care. "The madness of progress seems to affect the profession, and nurses worry about the quality of care provided. Could the dissatisfactions be a reaction to an inability to cope with the accelerating growth and the complexity of health services, or maybe the multiprofessional power structures in hospitals?"

Cormier told the delegates that many nurses are still not aware and underestimate the importance of participating in the decision-making process. The uneasiness in the profession is a temporary growing pain that is essential if the profession is to keep growing, she said. "I also believe that our nurses will become more and more flexible and that they will unite to speak with one voice."

During the business sessions, reports were submitted by the Executive Secretary, Registrar and the Nursing and Legislation Committees. The auditors' report was presented, the 1977 budget ratified and a total of 35 resolutions were presented and discussed by delegates. Approval was given to 23 resolutions, some of which are:

- to conduct a review of nursing home regulations
- to encourage nursing homes to adhere to the defined role of the RN and the RNA
- to establish a task force to identify the role and the needs of RNs employed in nursing homes, and provide support in setting up standards for those working in nursing homes and in education
- to investigate ways of increasing the number of nursing hours for each level of care in nursing homes and altering the criteria which determine these levels

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News

- to promote physical training and health education programs for school children
- to promote more community health teaching programs on the CBC network
- to place greater emphasis on health maintenance and promotion through increased monies available
- to complete reassessment of NBARN's organizational structure
- to clarify the roles and functions of the nurse in relation to other members of the health team.
- to encourage employers to give priority to hiring New Brunswick graduates over new nursing graduates from other provinces
- to promote a mandatory reporting law in New Brunswick on child abuse
- to promote the Code of Ethics among nurses and students
- to support the right of part-time nurses to the same privileges, inservice programs, salary increases and retroactive pay accorded full-time nurses.

Keynote speaker for the program day of the meeting was **Lorine Besel,** Director of Nursing at the Royal Victoria Hospital in Montreal and assistant professor at McGill University School of Nursing. Speaking on the theme, Day of Concern for the Future of Health Care, she stressed the importance of nurses' involvement in future health care planning.

How nurses can be involved in planning is the most basic and critical question, according to Besel. Only through involvement in future planning will nursing find answers to where it will fit if there are changes in health care delivery services, she said. Then nursing may be in a position to help decide the most rational proportions of hospital beds to ambulatory and home care services, and be able to direct educational programs to respond to those new nursing roles.

Besel pointed out that if nursing is not involved in the planning stages of health care, it will endlessly be left to ad hoc responses. She told the delegates that in talking about a Day of Concern, "we are expressing anxieties which we as a profession are experiencing." These anxieties are partly due to the lack of involvement in health care planning, she said.

Besel focused on external forces currently exerting pressures which are shaping the practice of the profession. She referred to three immediate concerns of nursing — unionism, consumerism and increasing government intervention.

Although the future of nursing is confusing and unpredictable, Besel feels that it is also exciting. "At one time our role was confined to hospital nursing and fairly uncomplicated. Today the very scope of possible activities to which a nurse's core skills may be applied is one of our problems in planning for education, practice and research," she said.

Newly elected members of NBARN executive are: *President:* **Judith Oulton** of Fredericton; *First vice-president:* **Judy Mann** of Campbelton; *Second vice-president:* **Bonnie Hoyt** of Fredericton; *Secretary:* **Lucille Gaulton.**

Personality profiles reflect new maturity

Nurses studying to become medical nurse practitioners in the U.S. show striking changes in their personality when compared with those of similar students a few years ago, according to an assistant professor and clinical chief of community health nursing at the University of Rochester school of nursing. Dr. Judith Sullivan studied medical nurse practitioners at the University of Rochester between 1972 and 1976. The nurses, all experienced RN's, came from a wide variety of positions in the western New York region.

Dr. Sullivan tested personality in terms of 15 personal needs. These needs, as evidenced by the responses to a large number of questions, were then ranked in order of importance in the makeup of the individual.

The needs measured were achievement, deference, order, exhibition, autonomy, affiliation (the need to be loyal and to please), intraception (the need to analyze motives of oneself and others), succorance (the need to help relieve distress), dominance, abasement, nurturance, change, endurance, heterosexuality, and aggression.

In 1972, says Dr. Sullivan, the predominant characteristics of the nurses tested conformed to the profile of nurses in general, as shown by extensive earlier studies. That is, the nurses tested showed the greatest need for endurance, deference, and order, with only one difference — they showed a greater need for change. In 1973 and thereafter, the needs with the highest overall scores were heterosexuality, dominance, intraception, change, and achievement. The traits previously ranked highest now ranked lowest.

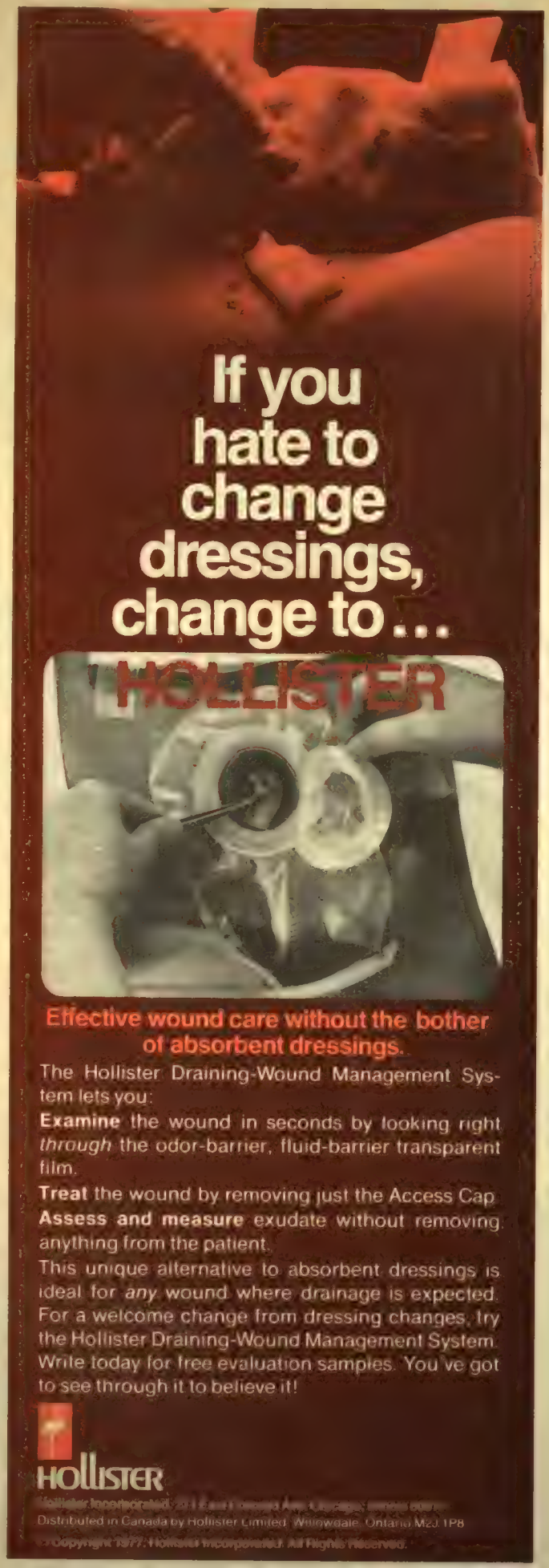
Dr. Margaret D. Sovie, associate dean for nursing practice at the University's Medical Center, commenting on the study, said, "The change in characteristics, as identified in Dr. Sullivan's research, reflects the growing maturity of the profession of nursing and its practitioners. These results are undoubtedly correlated with cultural as well as professional changes."





Canada recently adopted national standards for the application of CPR. "First on the list of people who have to be trained are those who work in critical care areas," says Penny Jessop, R.N., coordinator of the Ambulance Training Program for the Ontario Ministry of Health, Ambulance Services Branch. "From now until 1980 target groups for CPR instruction will include doctors, nurses, respiratory technicians, ambulance attendants and firemen." Jessop (pictured below) was instructing and examining at a recent CPR course held in Ottawa's Algonquin College.





News

NB RNAs set up separate organization

New Brunswick's 2000 Registered Nursing Assistants now have their own Act of Incorporation. Following study and amendments by the Corporations Committee of the Legislature, the Registered Nursing Assistants Act was passed on June 16, 1977 and was expected to be proclaimed law within 60 to 90 days.

The major amendment to Bill 36 revised the definition of the RNA. The nursing assistant is now defined as "a graduate of an approved school of nursing assistants who, being neither a registered nurse nor a person in training to be a registered nurse, undertakes the care of patients under the direction of a registered nurse or duly qualified medical practitioner, for custodial, convalescent, sub-acutely ill and chronically ill patients, and who assists registered nurses in the care of acutely ill patients, rendering the services for which he or she has been trained."

NBARN opposed the definition of nursing assistant contained in the original Bill on the grounds that it could jeopardize the quality of health care in the province by not assuring accountability of RNAs to the registered nurse, the person to whom they are responsible in the work situation. This objection, as well as other concerns, were voiced by NBARN representatives before a Corporations Committee meeting on May 26. The Association also presented a reaction paper on the proposed Act to members of the Committee.

Another source of concern to members of the Corporations Committee was the resolution debated at NBARN's annual meeting concerning the elimination of nursing assistant training programs. This resolution was subsequently defeated by the delegates attending that meeting.

A meeting held later in June between representatives and legal counsel from the groups concerned revised the definition of the RNA to the satisfaction of both parties. The Act approved by the Legislature contains the amended definition which stipulates that the RNA works under the direction of an RN or a physician. Another amendment provides for the setting up of advisory committees on education requirements and standards of care.

NBARN has had legal authority for registration, education and discipline of nursing assistants since 1957. The new Act will transfer these powers to the Association of New Brunswick Registered Nursing Assistants (ANBRNA). NBARN staff members who have administered the legal responsibilities in the past will be meeting with ANBRNA reresentatives to arrange for the transition prior to proclamation of the Act.

The incorporation of RNAs in New Brunswick as an independent body leaves only the Saskatchewan Registered Nurses' Association with legal jurisdiction over nursing assistants.

Nursing fellowships offered

Nursing fellowships for 1978 are being offered by the American Lung Association for graduate study in respiratory disease. The fellowships are offered to graduates of baccalaureate schools of nursing enrolled in an accredited graduate program in nursing and are directed towards those nurses seeking a career as clinical specialist, teacher or researcher in the care of patients with respiratory conditions.

The fellowships are in the amount of $6,000. per year with the possibility of one renewal for a maximum of two years of support. Awards are limited of U.S. and Canadian citizens or holders of bona fide permanent visas for study in U.S. institutions.

Completed application form must be received by April 1, 1978. Address inquiries to: *Marilyn Hansen, Consultant in Nursing, American Lung Association, 1740 Broadway, New York, N.Y. 10019.*

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News

NBARN brief on mental health services

The New Brunswick Association of Registered Nurses has submitted a brief to the sub-committee of the New Brunswick Health Services Advisory Council studying mental health services in that province. A more detailed submission on the subject will be prepared by NBARN and presented during a provincial tour by the committee this fall.

The three-member sub-committee, of which NBARN member Marianne Schwarz is a member, will present a preliminary report to New Brunswick Health Minister Brenda Robertson in September. An indepth report on the long-term aspects of mental health in New Brunswick will be presented at a later date. It is expected that NBARN's input into the Committee's investigation will be reflected in the report dealing with the long-term aspects of mental health services.

The Association's preliminary submission to the sub-committee on mental health supports the upgrading of standards of care for the mentally ill to equal the quality of care provided for those who are physically ill. Mental health services in New Brunswick must change greatly if this ideal is to be met, the submission states.

The submission makes six recommendations, the major one stressing the urgent need for hiring a mental health and psychiatric nursing consultant at the government level. The other recommendations support the need for all forms of continuing education programs, a post-basic course in mental health and psychiatric nursing in 1978, coordination of mental health services to provide continuous care from hospital to community, establishment of an "ideal unit" in each provincial hospital staffed by qualified RNs giving primary nursing care, and examination of basic nursing education programs with the goal of better preparation of nursing students. The submission also suggests that mental health services be regionalized, with each region responsible for the care of the mentally ill of the area; recruiting, preparing and maintaining required staff; and coordinating services that provide a high standard of care.

One section of the submission refers to the contribution of ideas and comments from nurses. The overwhelming response representing the views of more than 275 nurses from around the province indicates the degree of concern about this aspect of health services.

In responding to a question on why more RNs aren't working in psychiatric services, nurses spoke about inadequate and undesirable settings for clinical experience as students, and nurses being employed mainly for custodial care rather than being able to use their skills to the fullest potential. Other reasons cited for the lack of nurses working in psychiatric areas were listed as:

- lack of continuing education to help nurses develop new attitudes, knowledge and skills in this field;
- lack of direction and leadership in psychiatric nursing and mental health services in general;
- a ratio of patients to professionals and non-professionals which does not permit the practice of quality nursing care;
- lack of receptiveness to new ideas and approaches by persons in positions of authority;
- nurses in positions of authority not always qualified academically or in experience for their leadership roles.

NBARN's preliminary submission was prepared by Marilyn Brewer, part-time staff member, in consultation with NBARN's ad hoc committee on mental health and psychiatric nursing. Members of that committee are Ryllys Cutler (chairman) and Roberta Nevers, Fredericton; Jessie Baldwin, Campbellton; and Betty Poley, Saint John.

Did you know ...

More than 30 states and territories in the USA now have legislation allowing for the clinical practice of certified nurse-midwives (CNM), according to the American Journal of Nursing. The two latest states to permit licensure of nurse-midwives are Alabama and Alaska. In addition, legislation is pending in Colorado and Massachusetts.

New primary care centre opens in Montreal

The Montreal General Hospital has been awarded a $1.4 million grant in order to establish a new interdisciplinary Centre for Advanced Studies in Primary Care.

The Centre is to be a faculty development program in the Department of Family Medicine of McGill University. It will be co-sponsored by all the family practice units of McGill and several other departments in the Faculty of Medicine.

The grant was provided by the W.K. Kellogg Foundation of Battle Creek, Michigan.

The new Centre's primary objective will be to provide an advanced academic program for family physicians and primary care nurses who already hold or who will soon hold a university faculty position.

Doctors and nurses will be offered a two-year curriculum which will emphasize four broad areas of academic pursuit; investigative principles and practice, new teaching modalities, medical communications and a program development for health science institutions. Each student at the Centre will also participate in guided academic activities, which will include teaching, academic clinical practice and investigative projects with scholarly presentations.

Graduates of the Centre will not necessarily receive a degree or a diploma. Anyone wishing to be a degree candidate at McGill will have to register with the University Faculty of Medicine and comply with its postgraduate residency requirements.

The innovator, and designated director, of the Faculty Development Centre is Dr. Walter O. Spitzer. He is presently the Director of the Family Practice Teaching Unit at The Montreal General Hospital and a Professor of Epidemiology and Health at McGill University.

Dr. Spitzer has taught family medicine as well as epidemiology and biostatistics for many years and he brings considerable academic, as well as research experience, to the Centre. One of his foremost interests in the field has been research into improved primary health care services in

Dr. Spitzer emphasized the Centre will act as the nucleus and catalyst for satellite teaching centres now being organized in remote rural areas of northern Quebec and New Brunswick.

These outlying teaching units will include teaching teams made up of both family physicians and family practice nurses. Physicians and nurses from such satellite units and members of the McGill centre will rotate regularly to increase their mutual awareness of the challenges and demands of each area.

The Centre will accept its first students in July, 1977. Once in full operation, it will accommodate from 11 to 15 nurses and physicians.

Founded by the breakfast cereal pioneer, W.K. Kellogg in 1930, the Kellogg Foundation is among the five largest private philanthropic organizations in the United States. The Foundation supports programs in the areas of education, health and agriculture in the United States, Canada, Latin America, Europe and Australia.

Health happenings

A technique first developed to uncover flaws in the surfaces of industrial materials has been adapted to help uncover **early scoliosis** at low cost and without the need for highly-skilled medical help.

Essentially the technique is a way of throwing a series of '3-D' shadows on the back of the child being screened. If the spine is scoliotic, asymmetrical patterns are seen by the examiner at a glance. It is thought that this shadow technique is considerably more sensitive as a screening method than the bending test presently used in school screening tests.

The percentage of Canadian **non-smokers** has increased steadily for 10 years to 53.9 percent from 47.2 percent except among teenagers. In the last 10 years, teenagers have smoked more each year but the trend is now relatively stable.

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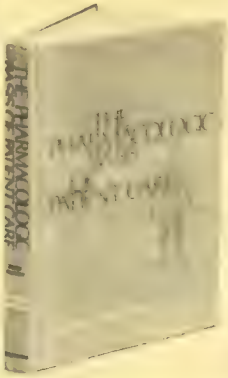
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TRI-HOSPITAL DIABETES EDUCATION CENTRE: *a cost effective, cooperative venture*

Elizabeth Laugharne, R.N.
George Steiner, M.D.

(Tridec)

Health care expenditures in Canada account for a little more than seven (7.3) per cent of the gross national product, compared to 6.8 per cent in the United States and 4.8 per cent in the United Kingdom.[1]

In Ontario — where the population increased by almost one and a half million people in the decade between 1965 and 1975[2] — health insurance costs during the same period skyrocketed from $350 million to close to $3 billion.[3]

Even before the introduction of the current austerity measures, intended to put a ceiling on continued annual increases, concern was being expressed by administrators and practitioners alike over the need to find more satisfactory long-term solutions to the twin problems of rising costs and increasing demands for services and facilities.

In 1974, members of the Ontario Health Planning Task Force[4] recommended that the focus of health services be shifted from the traditional hospital setting to community settings more accessible to the public. They suggested that there should be a built-in capacity to encourage new methods of health care delivery and to test new programs. Other recommendations concerning regionalization of health care, increasing the number of nurse practitioners and improving utilization of the primary health care sector have caused the Ministry of Health in Ontario to give belated recognition to preventive aspects of medicine. Since then, more emphasis has been placed on ambulatory as opposed to in-patient care, and efforts have been made to amalgamate services, to convert active treatment beds to chronic beds, to share some services and to close other facilities.

Tridec is an outgrowth of all these trends. The center recognizes the need of the diabetic and his family for adequate understanding of the nature of diabetes mellitus.

- It reinforces the concept that, to achieve such a goal the diabetic has to assume an active and participating role; the physician and other health professionals are available to help him assume this responsibility.
- Tridec provides a setting in which allied health professionals can update their knowledge of diabetes and improve their teaching skills.
- Coupled with this is the desire to create a model for a shared physicians' service with the primary objective of health education.

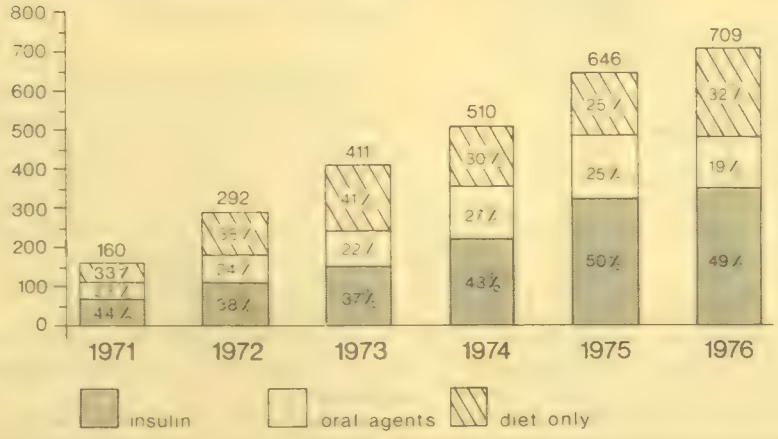
Staff and facilities

Tridec is a cooperative venture of Mount Sinai, Toronto General and Women's College Hospitals — three downtown Toronto university teaching hospitals which serve a mixed socio-economic population representing many nationalities, most of whom do not regard English as their first language.

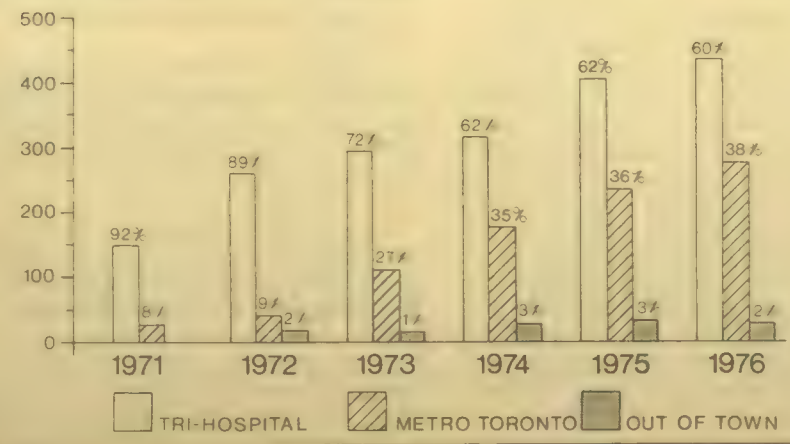
Host for the project is Women's College Hospital and it is here that the classrooms, offices, laboratory and lounge are located. In addition to the 1800 square feet of space needed to house the project, Women's College also provides administrative and back-up services such as purchasing, personnel, housekeeping, X-ray, emergency and laboratory facilities. Representatives of the medical and administrative staffs of the three hospitals sit on a committee which meets bimonthly to advise on policy. The paramedical staff — two nurses, two dietitians and a social worker — are screened by this committee and hired by the host hospital. Medical staff is provided on a cooperative basis by the three hospitals. Each of the ten

Six years ago, three teaching hospitals in Canada's fastest growing metropolitan area decided to pool their resources, share facilities and staff to develop a patient education program for the diabetic and his family that would emphasize preventive aspects of medicine and ambulatory care. The venture has paid off handsomely in terms of well informed, highly motivated patients and more effective utilization of costly hospital facilities. Here's how it works...

1 Patient registrations and treatment



2 Source of referrals



physicians cover for a week at a time on a rotating basis.

Tridec physicians do not take an active role in the treatment of registrants but are involved in a teaching and consultant capacity. Their main function is to teach the patients and professionals at the center and to serve as a back-up for unusual or emergency treatment problems. The referring physician remains the director of his patient's treatment. Tridec physicians will, however, at the request of the referring physician, provide a medical consultation during the patient's stay.

Day-to-day operations are handled by the nurse-coordinator under the direction of the medical director of Tridec and the medical director of the host hospital.

Utilization

Since its inception in 1971, Tridec has accommodated more than 2,000 patients for a total of close to 8,000 visits. More than 10,000 meals have been served to registrants.

The daily patient census of 16 diabetics is supplemented by relatives of these patients and several allied health professionals. Most of the patients are insulin dependent or managed on diet alone.The majority of diabetic registrants range in age from 20 to 50 years . There has been no significant change in age or duration of diabetes in referred patients since the program began. The percentage of patients on oral hypoglycemics has also remained constant since 1971 (see Figure 1). The pattern of referrals has, however, changed significantly. In 1971 when the center opened, almost all referrals (92% per cent) came from one of the three participating hospitals. By 1976, referrals from community physicians had increased to 38 per cent of the total (see Figure 2).



Informal classroom teaching session.

The program

The center presents a comprehensive four-day program which includes all medical and dietary aspects of the management of diabetes. Patients are grouped together or segregated according to their treatment needs — Monday through Wednesday for those controlled by diet or by diet and oral hypoglycemic agents and Monday through Thursday for those dependent on exogeneous insulin. Fridays are kept for staff to write reports, develop audiovisual aids and attend staff meetings.

Nutritional teaching and counseling is done by *teaching dietitians* who emphasize that balanced nutrition is the foundation of effective diabetic management. The diabetic diet is presented by the dietitians as simply a healthy way of eating which can be used by the whole family. A session on calorie control is directed to those patients whose principal goal is weight reduction. Breakfast and lunch are served at the center under the supervision of the dietitians and patients are responsible for selecting portions of food appropriate to their own diet. As well, each patient is seen individually by a teaching dietitian who prepares a meal plan which meets the individual's needs and the physician's diet prescription.

Nursing lectures provide information on:

- physiology of diabetes;
- complications of diabetes;
- the how and why of urine testing;
- insulin administration technique;
- pharmacology of insulin and oral hypoglycemic agents;
- hypoglycemia, foot care, ketoacidosis;
- drug interaction.

Individual counseling of each patient by nursing staff affords the opportunity to evaluate and assess the patient's understanding and acceptance of responsibility to manage his diabetes on a day-to-day basis.

Tridec *physician involvement* at a round table "Question and Answer" period for two hours a week encourages patients to ask questions about their concerns or perhaps have further explanation of a topic previously discussed in a more formal setting.

Each patient also participates in two hours of group discussion led by a *social worker* each week. These sessions are divided into two groups — those who are dependent on insulin and those who are not. Many Tridec patients have commented on how comfortable, supportive and enlightening this process has proved for them. Group discussions provide a climate for problem solving and also serve to reinforce Tridec's teaching program. Since diabetics are often anxious and uncertain when they commence the program — they do not know what to expect or what is expected of them — a conscientious effort is made to create an atmosphere of relaxation, informality and acceptance throughout the program.

Individual counseling by the social worker is done at the request of the referring physician, the patient or a member of the teaching team.

Special one-day counseling sessions are also arranged for pregnant diabetics, the elderly, people who are not fluent in English or who require a refresher course to assist them in making diet adjustments.

Professional training program

One of the most important aspects of the Tridec teaching program is its usefulness as an educational resource for allied health professions. For the *health educator* who works in the community or teaches diabetics in another hospital, this "Teaching the teacher" program provides a chance to:

- observe individual diet assessment, nursing evaluation and counseling;
- improve teaching skills aimed at diabetics of various ages, ethnic, social and educational backgrounds;
- develop interviewing and teaching techniques.

As well, involvement in the group process affords the health professional an opportunity to interact with the inter-disciplinary health team and to hear patients discuss as a group their feelings about diabetes and how they cope with it.

More than 700 allied health professionals, physicians-in-training and in practice have attended Tridec since it opened six years ago and the number is increasing rapidly each year (see Figure 3).

Community outreach

Tridec staff, both individually and as a team, travel widely, to give lecture presentations and workshops to health care workers in a variety of nursing schools and community health agencies. Inservice programs have been given in half a dozen Ontario centers, including Sudbury, Timmins, Goderich, Orillia and Sault Ste. Marie.

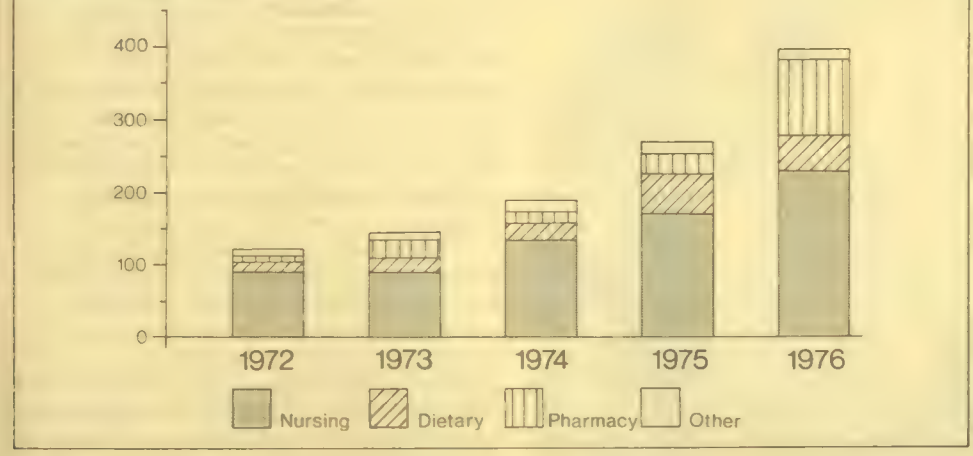


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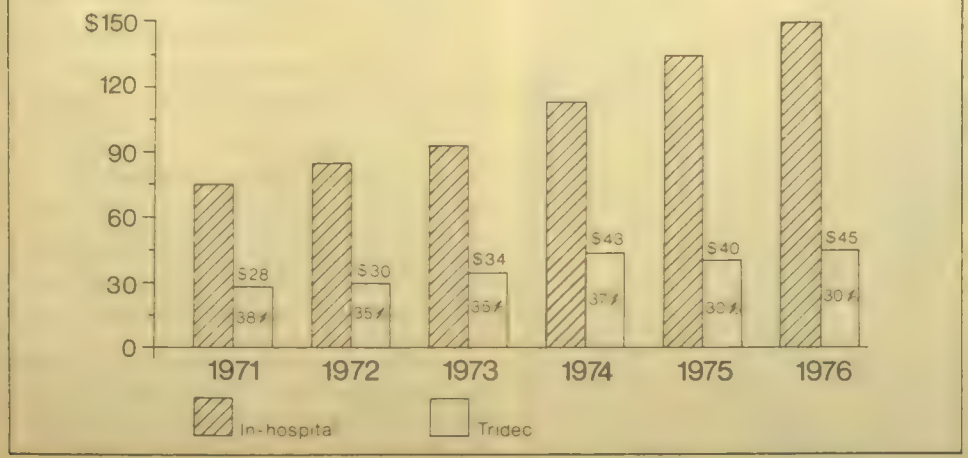
Individual patient interview.

*Increasingly, insulin therapy is being initiated and control monitored on an out-patient basis in community health facilities such as Tridec. Between 1973 and 1976 the number of Tridec patients referred for initiation of insulin therapy almost doubled (28 in 1973, 42 in 1974, 51 in 1975 and 51 in 1976). Acutely ill patients are still admitted to hospital but earlier discharge to Tridec has resulted in a substantial reduction of in-patient days. Since Tridec began collecting data on these patients, a total of 1,686 in-patient days have been saved. In 1976, this saving amounted to 500 hospital days or $79,500.

3 "Teaching The Teacher" registrations — allied health personnel



4 Operating costs-per diem per patient



Evaluation

1. *Cost benefits*

As part of its ongoing assessment and evaluation of the program, Tridec last year sent out questionnaires to each of the 247 physicians who had referred patients to the center during 1976. More than half, (54%) of the referring physicians replied, representing a total of four hundred and thirty-six patients (436) or sixty-one percent (61%) of the total 1976 registration (709).[5]

Information provided by these referring physicians (extrapolated to a 100 percent return) indicates that a total of 1,652 in-patient days were avoided by Tridec registrants in that period. At an average per diem rate per patient of $150,[6] a total savings of $247,800 is indicated in 1976. The total annual operating budget for Tridec over the same period was $102,000. Hence it is evident that the net saving to participating hospitals was substantial. In addition, use of Tridec facilities by diabetic patients results in the freeing of beds for other patients.

In assessing cost effectiveness, no attempt has been made to assign a dollar value to the educational aspects of the professional training program. If, for example, the center were to levy a charge of $100 per registrant, this would generate approximately $27,000 annually to offset operating costs.

In Ontario, the average length of stay in hospital for primary diagnosis of diabetes mellitus is 13.8 days.[7] Since Tridec's per diem rate is approximately 30% of the provincial average per diem cost of an in-patient day,[8] a clearly defined area of savings and substantial reduction in costs is achieved through the use of Tridec facilities by growing numbers of patients who are just beginning insulin therapy.*[9,10] (See Figure 4)

*In 1975, 138 referrals were made to public health nurses. This represents 21% of Tridec's patient registration.[12]



Cafeteria-style meal hour at Tridec.



2. Patient assessment
In Tridec's experience the patient accepts his diagnosis more easily as a result of support from group interaction. Follow-up in the community by public health nurses who evaluate the patient's understanding of and compliance with their diabetic regimen and report back to Tridec, has confirmed this objectively and subjectively. Group interaction has proven to be especially useful to those who have had insulin therapy initiated at Tridec.

Tridec nursing staff can teach the patient insulin administration technique during the four-day program in a setting that more realistically relates to the activity of the individual on a day-to-day basis. Coincidentally, this approach provides a better subsequent level of control than that achieved when the patient is confined to the inactivity of an in-hospital stay.

No attempt has been made to estimate the social benefits of the newly insulin dependent diabetic by reason of his more complete understanding of his condition and of an early coming to terms with it. Tridec staff suspects that these benefits are as appreciable as they are difficult to measure.[11]

3. Physician assessment
Control and compliance are difficult to determine precisely in settings such as Tridec, but referring physicians surveyed by questionnaire indicate that they feel their patients do benefit from the more structured approach towards achieving understanding of their condition.

At Tridec, the referring physician retains as close supervision of the effects of prescribed therapy as would be possible on an in-patient basis. By reporting to the referring

What is diabetes?

Diabetes is one of the most common diseases in Canada. It has been estimated that there are more than 100,000 undiagnosed diabetics in the country right now. In spite of this large number of "hidden diabetics," the disease is fairly easy to detect and if found early enough, can be controlled. If it is overlooked or not well-treated, it can quickly lead to complications.

What is diabetes? It is a chronic metabolic disease of unknown origin caused by a deficiency of the pancreatic hormone insulin and, as recent evidence indicates, an irregularity in the release of glucagon. In either juvenile diabetes or maturity-onset diabetes, the net result is:

1. The body cannot make full use of carbohydrate intake.
2. The pancreas produces insufficient insulin to convert sugars to glycogen for storage in the liver. Partial compensation is achieved by increasing the blood sugar in order to enhance glucose transfer into the cell, hence hyperglycemia. Instead of sugars, the body must use protein and fats as energy. The use of fats causes excessive amounts of ketone bodies (products of incomplete fat metabolism) to circulate in the body which can result in acidosis. Attempts to compensate for the acidosis result in hyperventilation and loss of sodium, potassium, chloride and water.
3. If the concentration of glucose in the blood is sufficiently high, the kidney is not able to reabsorb all of the filtered glucose and glycosuria develops.

An undiagnosed diabetic may exhibit the following danger signs: polyphagia, polydipsia, polyuria, loss of weight, easy tiring, slow healing of cuts and bruises, changes in vision, intense genital itching, pain in fingers and toes, drowsiness.

physician daily, Tridec staff provide informed feedback and work closely with him in achieving control for his patient.

Although figures are not available on any possible reduction in emergency visits or housecalls, physicians have commented on the reduced frequency of crisis calls originating from Tridec graduates.

4. Community follow-up

From the beginning, Tridec patients have been referred to community health agencies for continuing evaluation of knowledge and compliance with the prescribed diabetic regimen. Most of these referrals have gone to public health nurses who have become, in effect, an extension of Tridec's program. The cooperation of these agencies and their interest in Tridec's program is increasingly apparent[13] and it is expected that their contribution to the continuing care of patients with diabetes will be reflected in improved patient acceptance of their diabetic regimen and subsequent reduction in morbidity.

The future

The concept of patient education programs such as Tridec has many possibilities when applied to the preventive approach to health care. Chronic health problems such as obesity, hypertension, diabetes, and epilepsy (to name only a few) could be included in programs established within patient education centers. Mobile teaching units, educational materials in many languages and methods of evaluation and research are among the challenges that must be met. Health professionals should be concerned about effective utilization of costly health facilities and also about cost control measures.[14] It would seem that the answer lies in the pooling of resources, the sharing of facilities, more emphasis on preventive aspects of medicine and the handling on an out-patient basis of those services which should not require an in-patient stay .

Elizabeth Laugharne, *R.N. is the former nurse coordinator of the Tri-hospital Diabetes Education Centre in Toronto. She is past chairman of the professional health workers' section of the Canadian Diabetic Association and is a professional member of the American Diabetes Association. Presently, she is on a year's sabbatical and is co-editing a handbook for the pregnant diabetic which is slated for publication later this year.*

George Steiner, *M.D., F.R.C.P.(C) is associate professor at the University of Toronto. He is the director of the Lipid Research Clinic and director of the Diabetes Clinic at the Toronto General Hospital, Toronto. He is also a member of Tridec's executive committee.*

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CHILDHOOD DIABETES: *the emotional adjustment of parents and child*

Elizabeth F. Crosby



Diabetes is not in itself a barrier to a happy childhood and adolescence, for the child with diabetes can participate in all the normal everyday activities of life. At the same time, no one pretends that management is easy. For the parents and the child there are many new techniques to learn and new rules and routines to develop and follow. In most cases, however, this is not too difficult. The hard part for the family is learning to live with a chronic condition in a positive way.

The author of one nursing research paper[1] on the concerns of diabetic children and their parents had some very interesting observations to make about attitudes towards the condition. Of 16 diabetic children interviewed aged 10 to 17 years all of them indicated that having diabetes did not bother them particularly. They focused on the normal aspect of their life situation stating that they did not look different from their friends and that they were as active as their friends. The children stated that they could usually cope with problems that arose due to their condition. Parents of the diabetic children, on the other hand, tended to focus on the management problems of the diabetic regime and emphasized the condition rather than the 'normal life situation' of their child.

These are the two different points of view that must somehow join forces in order for the child to enjoy a healthy well-rounded life. Good control is essential but overemphasis of the diabetic regime can psychologically harm the child. The child and his parents must work together but the emphasis should be on the child and the responsibility he must take in controlling his condition.

Nurses who teach diabetic children and their parents need not only a thorough knowledge of the condition but also an understanding of the emotional needs of the child and the stages of adjustment of the parents.

The parents: phases of emotional adjustment

Stephen L. Fink in "Crisis and Motivation: A Theoretical Model."[2] has proposed four psychological phases which follow a sequential pattern in the process of adaptation to any stressful stimuli. The four phases are:

1. Shock
2. Defensive Retreat
3. Acknowledgement
4. Adaptation

Shock

When diabetes is first diagnosed in a child, it is the parents who experience the negative feelings — feelings of guilt and disbelief about the condition. In this stage, an individual may be in a state of disorganization so that he may not be able to think rationally. Both parents will probably be at this stage when they first learn that their child has diabetes.

The initial meetings the parents have with the nurse or other health personnel can help change their negative outlook to a more positive one. The nurse can be of help if she encourages the parents to identify and express their feelings about their child's condition. At this time, parents need to know that although the condition is not curable, good treatment and consistent management makes it controllable.

Defensive retreat

This stage is characterized by denial on the part of the parents. "It cannot be our child who has diabetes. There must have been a

A child with diabetes is first and foremost a child — with all the needs and desires of any child. Diabetes in itself will not prevent him from living a normal life. But learning to live with a chronic condition in a positive way is the challenge that diabetes poses for the child and his family.

mix-up with the blood." Reassurance to the parents that no mistakes were made, indicating complete confidence in the doctors and laboratory procedures, will help them come to an acceptance of reality.

Acknowledgement

At this stage the parents give up the past and start to face reality. This is when effective teaching about diabetes can begin. Until they reach this point, *simple* explanations of procedures will help reduce fear and anxiety. Education of the child and parents should be carried on together. An ideal situation is to have teaching centers specifically for children although this is not always possible.

At the Edmonton General Hospital Diabetic and Metabolic Centre, a four-day program has been developed for diabetics of all ages. In discussing management of the juvenile diabetic the program emphasizes that diabetes mellitus is a life-long condition, that each child and his environment is unique and that success in controlling diabetes means adherence to a pattern of routine. The aims of management are: to control the diabetes, to allow the child to lead a normal life and to teach the diabetic and his parents as much as possible about the condition.

During the four-day program, classes on the basic concepts of diabetes and its management are provided by the physician. The dietitian presents individual and group sessions on diet instruction. Nurses give individual and group instruction to diabetics and their parents on: detailed aspects of diagnosis and management with emphasis on urine testing, insulin administration, oral hypoglycemics; the importance of exercise; complications such as diabetic ketoacidosis and insulin reactions — etiology, causes and treatment; when to increase and decrease insulin dosage. The final class stresses the importance of proper hygiene and good control to the diabetic's general well-being. Late complications such as gangrene or retinal damage are not discussed with the parents at this time unless they specifically ask for this information. If the parents do ask about complications the nurse should answer their questions and also emphasize the importance of good control in delaying onset of these complications.

The child is expected to participate in his diabetic care. The young child can collect his urine sample and choose the site for his injection. The older child can carry out his own urine testing and prepare and inject his own insulin.[3] Including them in their own care increases their confidence and pride and facilitates their progress to independence. However, before such independence is encouraged, the child must be ready to handle the responsibility. He must comprehend certain fundamental concepts about diabetes and its management which he will obtain through experience and education before he is ready for self-care. In 1959, Dr. D.D. Etzwiler conducted a study on juvenile diabetics aged 6 to 17 at Camp Needlepoint, Minnesota. He found that in the majority of juveniles, the appropriate age for self-care was 12 to 13 years.[4] However, there is always individual variation and judgments must be made accordingly.

As nurses, we often become too involved in preparing the child and parents to handle the more technical routines of diabetic management. Inadequate emphasis may be placed on the emotional adjustments and the handling of psychological problems which may arise when the child returns to school and the community. Reaching the fourth step of "adaptation" is probably the most difficult of all the psychological phases of adjustment.

Adaptation

Adaptation and acceptance of the modification in health requires complete emotional adjustment. When diabetes occurs in a family, all members are affected. This is especially true when the condition appears in a child because he depends on others for supervision and management.[5] Family problems tend to surface; there may be conflict because of forced dependency on doctors.

One partner may blame the other because the child is diabetic and refuses to accept some responsibility for care. The nurse can be most helpful at that time by establishing an atmosphere in which the parents feel comfortable and can express their feelings. An effort must be made to understand their feelings and to maintain a positive attitude about their ability to manage this new situation. Remember the Social Service Department in the hospital and include them if family counseling seems necessary.

Parents will often devote themselves to their child's diabetes, being over-protective and oversolicitous, with the result that the child is convinced that he is handicapped. Johnny should still be their son Johnny, NOT their *diabetic son* Johnny. Parents who are domineering will insist on perfect control because anything less is not acceptable to them personally. Rejecting parents will want the child less when they find he has diabetes. Through patience, understanding, education and continuing emotional support the health team can help parents accept the diagnosis, adjust to new routines and supervise the child in an appropriate manner.



Emotional needs of the child with diabetes

The psychological reactions demonstrated by the child with diabetes can be better understood if we look at the basic emotional needs of every child.[6]

- The chief need of the child is to be *loved* by his parents and other important figures in his life. This love is usually spontaneous but in the presence of a chronic condition such as diabetes, the relationship between the parent and child can be strained.
- *Security* may be threatened because the child realizes that he is different from his peer group. Children want to be accepted by their friends and be "just like everyone else." Parents who tend to emphasize the disease process over the child's normal life situation can make the child feel "different." Tension between the parent and child can be created when the parent exaggerates the routines for good control. For example, parents may insist that Johnny be in the house at 1630 hours to void so that a second void can be taken before supper. A more relaxed routine that would allow Johnny to enjoy playtime with his friends would help him to feel like the "other kids." Parents need to learn early that flexibility in the routine is alright.
- The child needs to be accepted as an *individual.* If the parents do not accept the diabetes and its limitations, they will fail to accept their child.
- *Achievement* can be impaired by the limitations and frustrations of diabetes but it need not be. The diabetic child needs approval from his parents. Striving for perfect control of diabetes will frustrate the parents and make the child feel like a failure. Diabetes should not be a handicap. The child should be encouraged to develop his interests and competence in the activities for which he has potential.
- The struggle for *independence* is one of the chief characteristics of the child. This independence is threatened when a child has a chronic condition. Parents who demand that their diabetic child maintain "perfect" compliance to the "rules" of control or who exaggerate the seriousness of the condition jeopardize the child's ability to become independent. Proper initial instruction of parents and children with the child accepting responsibilities for his own treatment as soon as possible encourages development of a normal sense of independence.
- Another basic emotional requirement for children is *self-respect.* Adolescents are often preoccupied with their bodies and appearance. An integral part of their self-image is a sound body and any chronic illness may make the child feel inferior and inadequate. Children need help and guidance in order to gain good control of their diabetes without losing self-esteem.

Behavior problems

"... When they find they have diabetes it is the unusual child who is not, in some way, emotionally disturbed ...," says Dr. R.M. Ehrlich, Director of the Diabetic Clinic at the Hospital for Sick Children, Toronto.[7] Many adjust quickly and carry on, others become moody, depressed, angry and bitter.

Behavior problems that arise in the young diabetic child are often due to fear of the needle. He may not want to get up in the morning, may take 5 or 10 minutes to inject the insulin, may refuse to do it himself or may demand to be alone. Sometimes he is so resistant to the injection that he will have to be held down. Parents can feel at a loss in trying to deal with this situation. The nurse can tell the parents to give the child positive support — the injections do hurt but it will make him feel better, stronger, and relieve his symptoms.

Urine testing may also present a problem. At first, urine testing may be fun and novel but it soon becomes monotonous and routine. Because he may feel that he will get more approval if his urine test is negative, the diabetic child will sometimes test plain water rather than urine. It is important that the child is not made to feel that it is "his fault" if his tests are positive for sugar. Explain to him that the positive test means he needs more insulin. A comment like "Oh, 2% sugar, that's not very good." — can be interpreted by the child as a failure on his part.

Diabetic camps

A diabetic child can feel that he is the only one in the whole world who has diabetes. The benefits of a camping experience for such children are invaluable. It gives them a chance to associate with other diabetic children, to learn more about their diabetes and perhaps to become a bit more independent. The child sees that others are like him and that they can lead normal lives.

Adolescents can also benefit from a camping experience with other diabetic teenagers. In the Edmonton area, a group of teenagers organize a "Teen Wilderness Camp" each year. Ten to fifteen diabetics along with a doctor, nurse, dietitian and boxes of freeze-dried food spend a week on a canoe trip. It is a great time to share experiences and to learn about themselves and their diabetes.

Adolescence

A diabetic child who has adjusted emotionally to his condition will probably pass

into adolescence smoothly.[8] If psychological adjustments have been poor during childhood, however, problems are apt to develop in the teenage years. A child who has been overprotected often fears the increased independence which his parents are starting to give him. Transferring too much responsibility to him may be interpreted by the adolescent as a lack of parental love and he may rebel in an attempt to get more attention. For example, there are many reports of rebellion manifested by overeating, refusing to test urine and failure to take insulin.

Adolescence is perhaps the most difficult time to develop diabetes. At a time of great social, psychological and physical adjustment, the addition of the self-discipline required to handle the diabetic routine is often a problem for the teenager.

Help for teenagers

Education that emphasizes the "normal" can help the teenager accept his condition in a more positive way. The health team must strive to help him realize his potential as a person. He will still be able to meet people, make friends, plan for his future education and explore job opportunities. The diabetic teenager can still play sports, go camping, work part-time, babysit and carry on a normal life. It may help encourage him to know that many famous people have had diabetes and have coped with it well (Bobby Clarke, Mary Tyler Moore, H.G. Wells).

A satisfying social life is important to a teenager. He should be encouraged to participate in the school activities which interest him and should be independent enough of his parents that he can manage on school trips or stay overnight at a friend's. He should be able to choose wisely from the menu at a drive-in food outlet so that he can go there with his friends. Hopefully, too, he will have gained enough confidence to offer correct responses to comments from classmates about his diabetes.

Once adolescence is reached, the teenager is encouraged to participate in a refresher education program given at the diabetic center. Up to this point he has probably received most of his knowledge about his condition from his parents. Now he should have individual teaching to review the basics of control as well as to update his information about diabetes.

Follow-up of the adolescent is important. Now he can start to attend the center independent of his parents. In between visits he is encouraged to contact the doctor or the nurse if problems arise. Knowing he can count on the health team gives him a feeling of security and confidence.



All photos courtesy of Health and Welfare Canada Information Directorate

Summary

Diabetes is a condition that tests the character of the patient as well as the family. The two must share information, face the challenges of each individual situation and explore new ways of making diabetes easier to live with. As nurses, we must use all our knowledge and skill to establish and maintain supportive, interpersonal relationships with both the diabetic patient and the family.

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THE JUVENILE DIABETIC: *in or out of control?*

"Once I was at a sleepover. The next morning at breakfast I was just going to put a little syrup on my pancake and my girlfriend — she used to be my best friend — said, 'No, don't let her have any, she's diabetic.' And the girl's mother looked at me as if to say, 'What have I got here'?" — a 13-year-old diabetic girl.

"I go off my diet every day — I eat licorice every day. I tell my friends not to offer me any candy but they always do ... if I make something in Home Ec., like cake, I save it and eat it for lunch ... I'm always 5 (urine test)" — a 12-year-old girl, diagnosed diabetic for about one year.

Carol Polowich
M. Ruth Elliott

Comments such as these by juvenile diabetics are common and have important implications for nurses and others who will be involved in juvenile diabetes and its control. Juvenile diabetes, also known as "brittle" diabetes, is much more difficult to control than diabetes in adults, with a greater likelihood of diabetic coma. Just how well controlled are young diabetics after they are on their own in the community?

I first became involved with diabetes last summer when I worked with pediatric and adult diabetics at Burnaby General Hospital. At least two per cent of Canada's population have diabetes[1] and, therefore, contacts with diabetics either in hospital or in the community are very likely.

In preparing to write this paper I completed an extensive literature search and then visited diabetic facilities in the Vancouver area. I discussed some of my concerns with a variety of experts in the field: dieticians, nurses and doctors. I devised a survey questionnaire to find out what was really going on with young diabetics — those from the age of 11 to 17. My purpose was twofold:
1. to determine diabetic-related problems
2. to learn from diabetics what they thought they needed in their diabetic education.

I sent survey questionnnaires out to 12 youths with diabetes; 10 responded. All of these diabetics had been diagnosed for at least 10 months and the longest for 9 years, 4 months. All had been taught about diabetes and had been regular attenders at a diabetic day care program. I also formed a group of five diabetic girls in the



"Sometimes I pretend I'm having an insulin reaction if I see a chocolate bar on the counter (I'd like to eat) ...." — a 13-year-old girl with a six-year history of diabetes.

pre-adolescent/adolescent years from 11 to 13 at Lions Gate Hospital, North Vancouver. My purpose here was to determine and work with these girls on their diabetic-related problems. This group was made up of diabetics who had been diagnosed from six months to six years.

The importance that is placed on peer interaction in middle childhood and adolescence suggested that a group situation might help me complete my task. But, I found that in such a group, members tended to pair off and talk only to each other. This added another dimension to my work. I had to encourage total group interaction, rather than several individual dialogues.

Needless to say, I often became very frustrated in my efforts to promote interaction with group members who were unaccustomed to the group process. However, by the end of the fourth group session, the girls were listening to and questioning each other, with little assistance from me. I began to feel we were getting somewhere.

The group situation and the questionnaire responses indicated there are five major diabetic-related problems:

- urine testing,
- carrying an emergency sugar supply,
- wearing diabetic identification,
- adhering to the diabetic diet,
- explaining diabetes to friends.

The responses to the questionnaires I mailed out placed more emphasis on urine testing while the group sessions revealed considerably greater preoccupation with diet and with peer group concerns.

Clearly, there is no consistency in advice given by doctors to their young patients about the frequency of urine testing for control (See table 1). The literature recommends urine testing four times a day,[2] but, none of the young people performed tests this frequently even when it was advised. Only two performed their testing as often as their doctors' recommended and this was only when they were required to perform the minimally acceptable amount of two tests a day (before breakfast and before bedtime).[3] Two of the subjects admitted they did not meet even this requirement.

The double-void specimen (the testing for sugar content of a second urine specimen obtained 30 minutes after the first voided urine specimen) is a more accurate representation of the degree of the body's insulin requirements in relation to sugar utilization.[4] Two of the 10 subjects indicated their ability to consistently double-void. Of the rest, three were sometimes able to double-void, four indicated that it was usually possible, though not done.

In order to treat an unforeseen insulin reaction diabetics should carry some form of sugar with them at all times[5]. Of the 10 subjects surveyed by mail, one always carried some form of sugar, three occasionally carried it, and the remaining six, rarely or never.

The diabetic who wears appropriate identification can be given emergency treatment if he needs it much more quickly.[6] A majority, (eight out of ten surveyed by mail) constantly wore diabetic identification in the form of a bracelet or a neckchain. The two others wore identification only occasionally.

Data from the questionnaires shows there is a need to reassess the teaching of the young diabetic about the importance of urine testing for diabetic control. Through their behavior the young diabetics also indicated they need instruction on how they can achieve the double-void urine specimens for more accurate test results. One way to help them is to encourage their fluid intake immediately after the first void specimen is obtained. The importance of having an acceptable emergency sugar supply readily available should remain a prime teaching focus for the majority of young diabetics. Some reinforcement teaching is also indicated for the two diabetics who only occasionally wear identification pointing out their health problem.

Group Discussion

Diet was identified as a major problem with young diabetics in the group discussion sessions.

Member No. 1 (a diabetic for approximately one year): "I go off my diet every day — I eat licorice every day. I tell my friends not to offer me any candy but they always do ..."

Member No. 2 (a diabetic for approximately six years): "If I have an insulin reaction in the middle of the night I'm just so ravenous — I'll eat about seven Oreo* cookies, a piece of bread with gobs of peanut butter, about three glasses of juice and suck some candy ... the first few years you're a diabetic you're really scared what might happen to you if you go

* Oreo is a registered trademark of Nabisco Inc.

Table 1
URINE TESTING

Subject	Sex	Recommended tests per day	Actual tests per day	Double-voiding
1	M	3	2	sometimes
2	M	4	3	yes
3	M	4	3	no
4	M	2	0	yes
5	M	4	3	no
6	M	4	3	yes
7	F	2-3	1-2	yes, sometimes
8	F	2	2	sometimes
9	F	4	2-3	usually
10	F	2	2	no

This table shows the urine testing behaviors of the group surveyed by mail.

off your diet, but then you just get so tired of not being able to have anything (that you like) that you go off (your diet) and nothing really happens."

Thoughtful discussion of potential complications can assist the young diabetic to realize the necessity of adherence to an appropriate dietary regime. In a setting, such as a Diabetic Day Centre, it is possible to provide realistic dietary reinforcement teaching. Group and individual discussion about dietary problems can work to achieve the desired result of helping the young diabetic maintain a healthy balance between diet, insulin and energy requirements.

These are some of the ways I found of discussing dietary concerns with young people:

1. There may be times when you go off your diet. Remember that some foods are not as high in sugar as others. For example, an extra fruit would be better to eat than cookies, chips or a candy bar. If you do overeat or eat chips or candy, you should do some exercise to balance this off. The exercise should be done *the same day* and as close to the time of eating the "extras" as possible. Pick some activity you enjoy, invite a friend along and fit it in at lunchtime or after school. In other words, make a social event out of it.
2. If you are ravenously hungry between snacks or meals it is time to see the dietician and doctor about a new diet plan and possibly an insulin change. As you grow, your body puts in new requests for energy supplies, so adjustments continue to be necessary to meet these new demands.
3. If you are ravenously hungry when an insulin reaction occurs, take appropriate food or drink in *moderation,* for example, a cookie or small can of juice. It will take a few minutes for the food to reach your stomach (and your blood stream) to turn off the hunger sign in your brain. Stuffing yourself with too much food all at once can lead your body to suddenly demand more insulin than you have available.

Peer reactions

Explaining diabetes to their friends emerged as another important issue in the group discussions. I asked the group members to discuss what they could say to their peers whenever they were offered food or drink that is forbidden on their diet. The group members unanimously agreed that kids at school and the public in general should be educated about diabetes. But, some of the diabetics said, "... it's too hard to explain," or "... they wouldn't understand."

The kids said their friends were confused because some diabetics tell them "diabetes means you can't have any sugar or candy," and yet they do see them go off their diet, or take some sugar in an emergency.

I found it best to encourage each diabetic to feel comfortable in explaining and interpreting diabetes to friends. Role-playing can be a useful technique in this situation. A discussion based on the following four questions can help the young diabetic with some of his uncertainties:

1. How do you feel when you are having an insulin reaction?
2. Why are you having the reaction?
3. How do you tell someone about what is happening to you?
4. What do you do whenever you have a reaction?

I tried to tell the patients that explaining, on the spot, plus a more consistent diet pattern, is a good way for them to enhance their friends' understanding of diabetes. In other words, by example, rather than by words alone.

Areas for education

The young diabetics surveyed by mail provided suggestions for what they believe a new diabetic should be taught and told:

- "It is important for a new diabetic not to feel he is different from other people... (Education should not be) limited to things he can't do ... (Stress) importance of diet and exercise ... what insulin is and how it controls diabetes."
- "How to inject a needle and how to take care of it and carry some sugar and stick to a proper diet ..."
- "*Why* you should test your urine, *why* you should always stay on your diet, *what* insulin does in your system ..."
- "A new diabetic should be taught to do their own needle because if they don't, they probably would want their mother to do it all the time, like I do, but I've learned to do it. They should be told that it is important to have the needle because if you don't you become very ill."
- "Not to feel sorry for yourself, their (sic) is other people an awful lot worse than you. Not to stop doing things your

(sic) use to doing just because you have diabetes."

These comments indicate some of the emotional needs and teaching-learning requirements of pre-adolescent and adolescent diabetics. Are diabetic educators, hospital and community health care personnel sufficiently aware of these needs?

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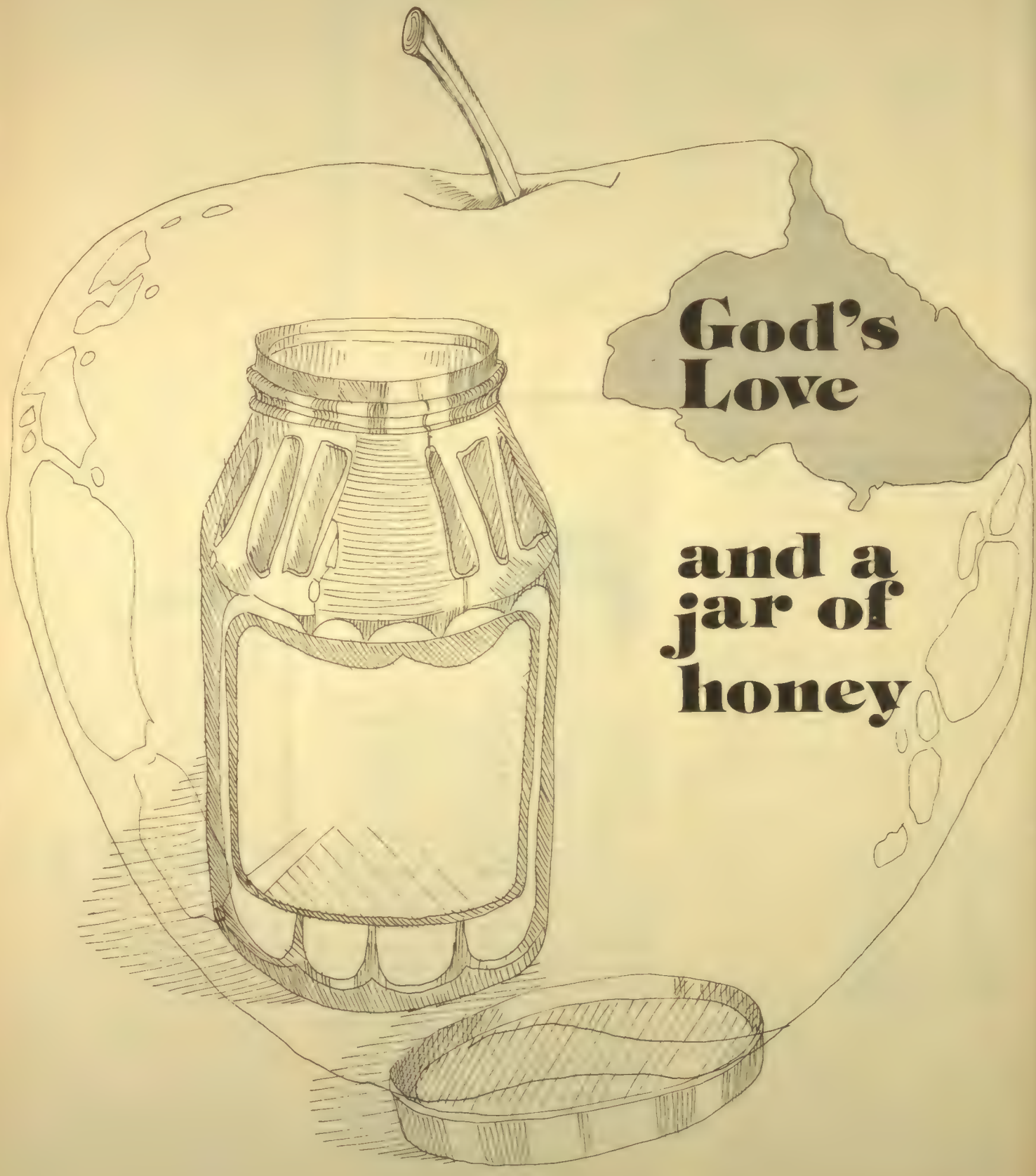
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God's Love
and a jar of honey

Dawn Moynihan

The first time I saw Angie I was too busy ducking a flying supper tray to worry about formal introductions. A dish of applesauce just missed my student's cap as I cautiously entered the ward. A classmate and a graduate nurse were trying unsuccessfully to calm an elderly, enraged patient. As I drew nearer, part of her ammunition splashed against my ear and a wet, soggy teabag dropped at my feet. A pair of enormous, bright blue eyes glared at me. I realized that a strange face would only add to her uneasiness and decided it was time to leave. What I hoped was the last of her weapons, a flying bedpan, preceded me out the door. Later, I heard that none of the nurses had been able to control her and that sedation had little calming effect on this ninety-five-year-old lady.

Not long afterwards, I came on duty to find that Miss Angie McIntyre had been assigned to me. Understandably enough, she was to be my only patient. Doubts about my nursing abilities came flooding over me as I made my way to the ward. I decided that it was time to consider a career as a secretary, a nun, a lady wrestler, or any other less hazardous profession. A skinny nineteen year old, I hardly felt a match for the eccentric ancient.

By this time, I was near her bed. As I gazed down at her sleeping form, peaceful and childlike, I couldn't help but think that she reminded me of a sleeping volcano, waiting to glorify itself in a new eruption. As I turned to leave, the sound of my black oxfords awakened her. Turning again, I saw trembling hands searching for the bed railings to raise her frail body. The same angry eyes. Did I see fear there also?

"Who are you?" she roared. "What do you want? Get out."

All my remaining confidence left me. Even today I don't know how I managed to whisper, "Dawn Herrington. I'm a student nurse." And then it happened.

"Well, Donna McLennan. It's about time you showed up. I was beginning to think there were no more "Scotties" left in this world. Would you get me my apple, please?"

I hurried away to get an apple, stunned at the change in her. At least there was no applesauce in orbit! Apparently, Angie did not consider me a threat and that was something. When I returned, she asked me all kinds of questions about myself, and I answered them truthfully. But I didn't ever tell her that my name wasn't Donna McLennan.

Apparently Angie decided that I could be trusted because in the days that followed, she allowed me to nurse her, feed her and tease her. We had so much fun that sometimes I wondered which of us was nineteen.

Periodically I would see an Angie that I could not get through to. At these times she did not know me. Sometimes she would sit up in her bed and re-arrange all the bedding, winding the sheets in and out between the bed railings which she often referred to as her monkey-cage bars. She would do this for hours and then fall, exhausted, into a deep sleep. At other times she spoke to God, telling Him off for this and that, or thanking Him for all His gifts to her. Somehow I had the impression that they were old friends.

Angie had broken both her legs in a fall while she was living in a nursing home. Her legs were in two casts joined at the waist. For long periods of time she would work at the stockinette in the newly changed casts and then put her "treasures" inside them. These consisted of a bell, a set of very loose dentures, her glasses, sometimes even some crusts of bread.

Often when she talked to me, her dentures would fall out. I suppose it sounds absurd, but I loved to watch her try to master them. Sometimes also her shaky fingers would ease her thin white hair upwards until she had it all collected into some form of a knot ending in a curl. It would take at least half an hour for her to accomplish this. Then she would call out "Donna," and I would have to run and locate her blue hair net which she had often stuffed in the "safety deposit box" formed by her casts. Then she would ease it over her hairdo and settle down for a sleep.

I grew to love this old lady. Sometimes when we talked she would ask me about my "men-friends." As a girl, she told me, she had loved a young man named John. Her family had considered him a nobody, she recalled tearfully while searching her casts for her hanky. But she had loved John and, she maintained, still did. She wondered if he ever thought of her. I hadn't the heart to tell her that I was almost certain John must have died years ago. Angie never married and many, many times she warned me never to lose my love as she had.

We often spoke of important things. Our biggest argument was over the relative merits of an apple and a jar of honey. I maintained that with God's love and a jar of honey, I could do anything. She thought the benefits of a daily apple outweighed the honey. As soon as she was better we would go bowling and she would prove her apple's worth.

Then came the day Angie left our hospital to return to her nursing home. Probably she would never walk again since by picking at the casts she had loosened them and lessened any chance of normal healing. She left tearfully, making me promise to visit her. I promised to come to see her as often as possible although I would be moving shortly to another town. There was a chill in the air as they wheeled her to the waiting ambulance.

I wrote often, hoping she would realize who the little notes were from. The day I visited her at the home a nurse warned me that she would not know me. But the moment I entered the door, I heard her whisper "Donna." Tears came to my eyes: she had failed so much. Nevertheless, she munched away on the candy I had brought, the loose dentures interrupting her flow of conversation. She ate so much candy that I was frightened she'd be ill but she informed me that "people often came into her room at night to steal." So — the more she ate, the less they could steal. From under her pillow she brought out one of my notes which she had managed to hide from the night robbers. Apparently, the nurses had read them to her and she wanted to know more about how I was. It was hard to leave, knowing our visits were dwindling.

I saw Angie several times after that. Each time, she was bright, excited to see her Donna. Once, she tried to remove a gold ring from her finger to give to me. It was all she had, and she wanted me to have it. It would not come off and I was relieved, really, because I would have been reluctant to take it knowing that her relatives might think that I had taken advantage of her. It was a funny old ring, more like a tiny belt with a locket. I often think of it now and wish I had it .... because it was hers.

I finished my affiliation at the out-of-town hospital and returned to find Angie had been re-admitted with pneumonia. I visited her every day until once more I was off to another town and another affiliation.

Angie recovered amazingly fast and by the time I returned was in another home. When I visited her, the nurses once more warned me she was very ill and recognized no one. This time when she whispered "Donna" my heart ached for her. She had failed considerably, but clung to my hand with amazing strength. Gently she told me that if I really thought the jar of honey was better, to go ahead and eat it. I knew from the way she said it, that it was her way of saying how much she cared for me. Once more she tried to remove her ring from her long, bony finger. But it would not come off. It had been part of her for so long that it could not leave her now. When I left, she seemed stronger and I was sure I'd see her again.

Two weeks later, however a friend broke the news that Angie had died in her sleep. I am sure now, as I was then, that before she died Angie whispered "Say goodbye to Donna for me and tell her not to forget about that apple."

The author of "God's Love and a Jar of Honey," **Dawn Moynihan,** *is a graduate of the class of '61 of the Cornwall General Hospital in Cornwall, Ontario. In the past few years she has developed her talents as a writer and is now a free-lance writer specializing in children's literature.*

FRANKLY SPEAKING

NURSING EDUCATION: ANOTHER TOWER OF BABEL?



Mohamed H. Rajabally

Professional beliefs — these are the meaningful answers to the basic questions that all thinking professionals ask. The past few years have seen the nursing profession caught up in a search for beliefs that are suited to its changing role. The winds of change that have swept nursing along in the last decade have been both refreshing and rewarding, but we need to take precautions so that these winds do not simply blow us away.

The academic landscape of North America is littered with the wreckage of long-range educational plans; if the term "wreckage" is too strong, I suggest that "damaged prows" is no exaggeration. Plans fail for a variety of reasons; most of the time they are either too inflexible or too visionary.[1] Blueprinting for the future of the nursing profession is no exception.

Academic disciplines in transition tend to become philosophical and speculative about their status, function and future. Likewise, a profession tends to cast about for a suitable self-image while it is changing. Sometimes, however, the transition process creates puzzling answers to the questions posed by change.

A look at the nursing process

It is an exaggeration, if not sheer dishonesty, to dress-up the problem-solving approach (which a man uses daily from the moment he awakens) and call it "the nursing process" in an attempt to make it unique to nursing. I find it amazing that so many nurses are seduced by such deception .... Educators scramble to integrate nursing process into their curriculum; text-books are revised and rewritten, consuming time and money; and perhaps worst of all, students lose valuable time trying to learn something that they ought to know and use simply because they are rational creatures.

What seems to be indisputably unique to nursing is the tendency to complicate nursing practice under the guise of professionalism and accountability. If we are honest with ourselves, we realize that one group within the nursing profession that ought to be accountable directly to the consumer is the group of nurse educators. We must ask ourselves — what is it that the consumer demands? Like concerned parents who want a return to the basics in education, consumers of health services cry out for better nursing care, not more elaborate theories to add many more pieces to an already complicated puzzle. And instead of better nursing care, we add theories to theories, accomplishing perhaps confusion instead of accountability, and catching the bedside nurse in the cross-fire.

All those little arrows ...

Only a few years ago, general system theory was "in vogue," just as rock and roll claimed the fifties and theories on death and dying consume the seventies.

The fashion in nursing today is the "conceptual framework," so that it has become virtually illegal to teach nursing without it. But an editorial by Edith P. Lewis aptly describes the confusion introduced by the use of the conceptual framework and its attending models. "All those little arrows pointing both ways and going off in all directions at the same time; the circles within the circles overlapping circles; the boxes spawning more boxes and sometimes three-dimensional cubes in cross-section — all of these sometimes do more to confuse than to enlighten."[2]

Can we document the fact that better learning and understanding occur when a model is used or that using a model improves retention of knowledge and provides better nursing care? Or on the other hand, can we show that nursing taught without a model results in inferior learning, retention, and practice?

The common defence for the use of a conceptual framework is that it provides a series of reference points. If I may put it in colloquial terms: a man needs a place to hang his hat. This defence is based on one of three assumptions: (1) that one wears a hat, (2) that one has a head, and (3) that even if one has a

In their eagerness to bring nursing into the realm of scientific status, the academics within our profession have, sometimes unknowingly, created an enormous puzzle, one that a bionic woman would find difficult to assemble, let alone the average practicing nurse. The number of parts to the puzzle are growing: the nursing process, conceptual framework, standard care plan, quality assurance, voluntary continuing versus mandatory continuing education and a host of new categories of nursing personnel, are some of these parts. Granted, we are looking for a professional self-image suitable to our emerging role. But let's take a closer look at the puzzle we are creating ...

head, he still needs something to hang his hat on.

In an attempt to discover why the use of a conceptual framework is so important, I began a search of nursing literature. I was drawn by the title of an article by Barbara Redman, "Why Develop a Conceptual Framework?"[3] but unfortunately, it didn't seem to answer the question it posed. I fail to understand why anyone would want to use a device that alters perceived reality. (Johnson's contention is that a model is drawn from reality and pertains to reality, but does not constitute reality[4]).

Digging deeper, I found that according to Levine's theory of holistic nursing, four principles are useful in planning and implementing care: the individual's needs for energy, and for structural, personal and social integrity. These are termed conservation principles because care is centered around the preservation of personal well-being.[5]

Levine says that when planning and providing care, the student must consider the sources of a person's energy and how he is using it.

This is patently absurd. Don't nurses (doesn't anyone?) know that the sources of a person's energy lie in the consumption, digestion, and utilization of food and nourishment, especially carbohydrates, not to mention oxygen intake and the elimination of wastes? In any event, how can the student concentrate on what she is doing if she must constantly think of the model?

The adaptation models described by Helson[6] and Roy[7] are thought-provoking. The adaptation model regards each person as a unique individual (is this new?) who constantly responds to internal and external stimuli by means of adaptive responses. The model believes that people are not satisfied merely by reaching a state of equilibrium, but rather strive constantly for the greater satisfaction associated with activities and goals requiring an even higher level of adaptation.

So far so good. Now comes the application of this theory to nursing practice. When students are planning patient care, they must not only identify the patients' problems but must attempt, often in a state of frustration, to classify them as focal, contextual or residual. I wonder why we encourage these classifications. I would expect students to deal with problems identified in order of priority, regardless of their classification.

More Towers of Babel

Despite recurring challenges to the direction the nursing profession will take, nursing educators, like little engineers, keep erecting Towers of Babel. Margretta Style writes of our response to these challenges: "In the interim ... task forces the world over labored to identify and elaborate processes, concepts, strands and themes which would be sufficiently comprehensive, yet sufficiently specific to the practice of nursing .... The result is a few major patterns with myriad variations — for example, nursing process, human development, adaptation, interaction, or health-illness continuum — all spelled out on diagrams, called models or systems, often resembling very complex electrical circuits or realistic arts."[8]

I wonder too at our apparent desire to eradicate the influence the medical profession has had upon us — doesn't this also indicate some degree of irrationality in nursing? It seems to me that any such trend is unfortunate, because, medicine and nursing seem to go together like shirt and trousers (or skirt and blouse) — remove one part, and embarrassment follows.

Perhaps if we are in fact so antagonistic towards all things medical, we shouldn't really be heading for doctoral degrees in nursing. After all the first people to be called doctors were not nurses.

It was interesting to read that eleven nursing experts from certain European countries recently gathered in England to take a look at this magnificent thing called the nursing process, available only in North America.[9] (Pity). Our European counterparts will hold other meetings, meetings scheduled to spread over an eight-year period, before they decide to integrate the nursing process into European nursing.

Maybe there is a lesson in this for all of us. The nursing profession is moving ahead all the time. Time isn't running out. Why can't we assess before we implement?

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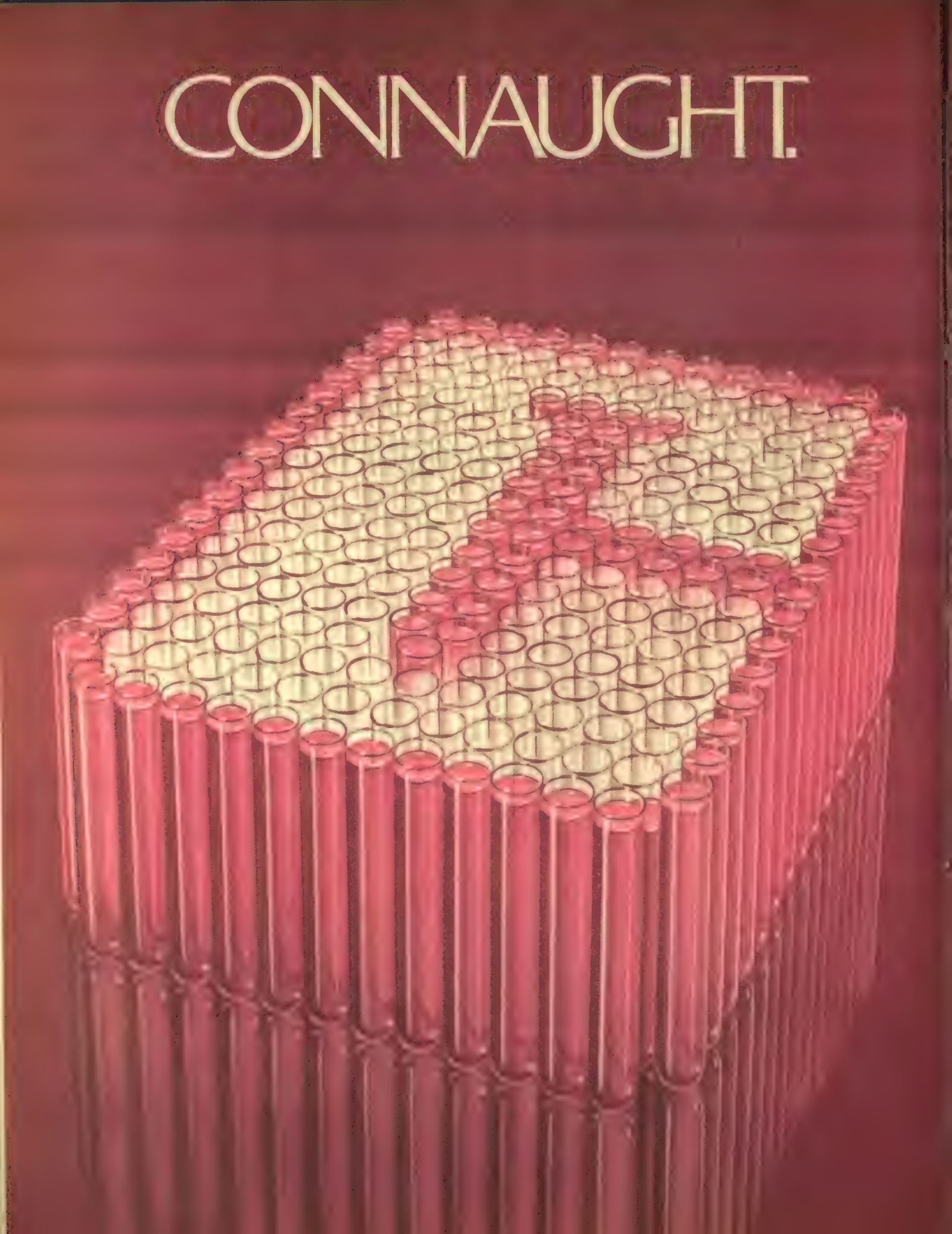
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HOW DO YOU FEEL ABOUT... *working nights?*



When it comes to patient care, nothing could be more obvious than the fact that it is a 24-hour affair. Shift work may well be the bane of existence for the administrator juggling time sheets and for the staff nurse working a stretch of graveyards. But we all realize that it is a necessity. If we don't like it, we still have to live with it, because, "Some must watch while some must sleep".

Perhaps because night shift turns us upside-down, because it makes most of us feel physically uncomfortable, the problems inherent in working nights are of great concern to us.

Last fall, CNJ published a questionnaire to see how you, our readers, feel about working nights. In all, 1,175 questionnaires were returned to us, many of them with your comments and concerns attached. Of the questionnaires analyzed, 64 per cent of our respondents indicated that they only worked nights because they had to — responses to other questions seem to indicate why ...

Lynda Fitzpatrick

How do nurses feel about working nights? We are all familiar with the complaints of our colleagues caught up in the night shift blues, familiar too perhaps with our own nagging discomforts and general lack of energy when it's our turn to work nights. The majority of responses to our questionnaire showed some degree of dissatisfaction related to night duty. Although responses could generally be grouped positive or negative in nature, they also made one thing very clear, that each came from a unique individual, with his/her own reaction to the problems attending night work.

There are nurses (a puzzle to some of us) who find night work rewarding — greater independence was only one of many reasons cited for enjoying the night shift. We found that 12.7 per cent of our respondents said that they worked nights simply because they wanted to. One nurse signed herself "A very happy nurse who loves to work nights."

Not surprisingly perhaps, this small group indicated few physical or psychological disturbances attending those periods when they worked night duty. Adding up the number of negative responses or complaints about night shift, we found that those who work permanent nights have in general, few complaints about the shift.

About our respondents

The majority of our respondents are, as you would expect, those nurses who are now involved in working night duty. Most said that they presently work night duty on a ward, are full-time employees, and work either three eight-hour shifts, permanent nights or night and day shifts (See Table 1). 84.4% of our respondents work short periods (up to seven days) as opposed to long stretches of night duty.

In cross tabulating the data, we found significantly different responses from those who work nights out of choice and, on the other hand, those who work nights because they have to (i.e. hospital policy). We also found that those nurses who prefer to work nights rather than evenings or work nights for personal reasons tended to express moderate views.

What made the answers to our questionnaire most interesting were the letters accompanying them — typewritten pages, notes printed around the margins of the questionnaire, or admittedly scrawled after a particularly exhausting night. Many of these letters expressed the feeling that more attention should be paid to such a fundamental aspect of nursing. "It's high time," said one respondent, "that concrete efforts were made to assess nurses' individual and collective reactions to working shift. The topic needs illumination, and some good hard thinking. After all, our profession is a health profession."

Rest

The majority of our respondents (64.1%) complained that they had some difficulty sleeping after working night shift. Further analysis indicated where this complaint originated — the majority (73.5%) of those who work nights on a voluntary basis deny any problems sleeping, whereas 76.2% of those who work nights because of 'hospital policy' indicate that they do have problems sleeping. Many nurses expressed their feelings on returning home from night shift in negative ways. "I feel too keyed up to sleep, and I'm already dreading the night to come." "I'm so physically and mentally exhausted, yet I'm unable to relax." "I feel awful, depressed, and sick, like I've forgotten to do something very important."

Other respondents, who just termed themselves "very tired" when they arrived home, complained that noise, and other distractions kept them from sleeping restfully. They complained that they could only sleep for a short period of time, that their sleep was light, inadequate. "Working any other shift, I don't think about sleep, I just do it, and I'm never tired ... working nights, I have this compulsion to store up sleep in case I have a busy night ahead, so I'm always restless and sleep poorly."

These feelings are reflected to a certain degree in the use of medication to induce sleep — of those working nights out of preference, only 10.8% take medication to sleep either occasionally or regularly; close to 1/3 of those working nights because they have to, occasionally or regularly find medication necessary for sleep.

Those who prefer nights are also more consistent in calling themselves 'well-rested' while working nights (60.2% consider themselves well-rested). Only 11.7% of those working nights because of hospital policy describe themselves as well-rested; 38.1% respond that they do not feel well-rested during a term of night duty.

It appears then that voluntary night workers on the whole feel content or cheerful after night shift, have less difficulty sleeping after shift, need medication less often to induce sleep, and generally feel well-rested after night duty. It is interesting to note however, that a minority of those preferring to work nights *do* have difficulty sleeping, *do* find medication necessary for sleep, and that 2.4% *do not* feel well-rested after night duty.

Eating Habits

Cross analysis also proved interesting as far as the eating habits of night nurses are concerned. A majority (69.1%) of voluntary night nurses said that they experienced no change in appetite when they worked nights; 73.0% of those working nights because of hospital policy said they experienced change in appetite. Almost half of this group describe their eating habits as poor, compared with 7.2% of voluntary night workers.

Weight fluctuation, perhaps a more reliable indicator of change in eating habits, also shows a marked increase in those who do not work nights out of choice.

Poor eating habits seem to derive from a constant nausea, or a feeling of imbalance: "My stomach works day shift when I am on night shift."

Those who prefer nights aim their complaints more consistently at the way in which their hospital is run at night: "Hospital cafeterias should be open at night so that staff can leave the wards for a relaxed supper break and proper meal. Hot meals at night are a necessity. Buying a cold, stale sandwich from a vending machine and bringing it back to the ward is pretty revolting."

About our respondents

Table 1

83.6%	presently work nights
16.4%	have worked nights in the past
61.3%	work on a ward
28.1%	work in a specialty care unit (ICU, PAR, Emergency)
10.5%	other — small hospital, supervisory position, etc.
84.4%	work short periods of night duty (up to seven days)
15.6%	work blocks of nights (two weeks or more)
40.3%	prefer to work short periods of night duty
12.4%	prefer to work blocks of night duty
47.3%	prefer never to work nights
43.0%	work three 8-hour shifts
4.7%	work only evenings and days
14.2%	work only nights and days
9.5%	work 12-hour shifts
10.1%	work permanent days
1.1%	work permanent evenings
17.5%	work permanent nights
77.8%	work full time
13.7%	work regular part-time
8.5%	work casual part-time
12.7%	work nights because they want to
14.2%	work nights in preference to working evenings
64.3%	work nights because of hospital policy
8.9%	work nights for other reasons (especially family reasons)

Relating to Others at Work

Working with others on night duty, do you find yourself as communicative as usual, do you find communication productive; are you as open to the emotional needs of your patients?

Again, the responses of voluntary night workers are more positive in nature. Only 2.4% of this group found themselves less responsive than usual to their patients' emotional needs, and comments from this group seemed to express the feeling that communication with patients was often enhanced during the midnight hours:

"I feel more empathetic towards patients at night — they need so much more during the dark hours ... when their pain and their fears are more pronounced, they need my reassurance."

"Nights provide me with the time and opportunity to talk to patients, they let their worries surface more easily and I can sit and listen and really do bedside nursing."

In contrast, 41% of the nurses working nights due to hospital policy described themselves as less empathetic than usual, a description that is not surprising when it is considered in conjunction with the degree of discomfort that this group tends to associate with night duty. These discomforts grow into quite a lengthy list, but the most common are tiredness, nausea, indigestion, headache, cold, constipation, restlessness, eyestrain, weakness, heaviness, bloating, nervousness, and dizziness. Any combination of these complaints could impede relationships with patients. "Physically and emotionally I was so low. After a long period of night duty I felt so bad I couldn't detach myself ... I was feeling so much for patients that I couldn't help them."

Communication with other workers followed a similar pattern; those who prefer night duty enjoy positive relationships with other staff more consistently than those who have to work nights. The latter find themselves quiet, annoyed or withdrawn.

"As yet (after five years) I have been unable to take pride in my care at night."

"I'm restless and irritable with everyone, staff and patients. I find it hard to be understanding, and that bothers me."

Alertness at work

Anyone who has worked nights knows that they are not always as quiet as subdued lighting in the corridors might seem to indicate. There are still emergencies, still patients in need of alert and skilled nurses. How do we react on night duty to those times when we really need our wits about us, when we need to be sensitive to those sometimes subtle clues that tell us something is wrong, when as at any other time, we need to be clear thinking and quick in our actions?

Fortunately, most of those nurses answering our questionnaire seem to respond

Some of your responses

		Prefer working nights	Prefer nights to evenings	Hospital policy
Do you have difficulty sleeping after night shift?	no	73.5%	47.3%	23.6%
	yes	26.5%	52.7%	76.2%
Do you feel generally well-rested while working nights?	yes	60.2%	26.1%	11.7%
	somewhat tired	37.3%	57.6%	50.2%
	no, very tired	2.4%	16.3%	38.1%
Would you describe your eating habits while working nights as comparatively	good	92.8%	66.7%	54.0%
	poor	7.2%	33.3%	46.0%
In relation to your patients' emotional needs, how would you describe your reactions on night shift?	more caring than usual	34.9%	16.7%	12.0%
	unchanged	62.7%	58.9%	45.6%
	less caring than usual	2.4%	24.4%	41.0%
	uncaring	—	—	1.4%
Do you find it difficult to carry on such functions as shopping, banking, keeping appointments, etc. while working nights?	yes, very difficult	6.0%	28.0%	45.2%
	moderately difficult	42.2%	52.7%	41.4%
	no problem	51.8%	19.4%	13.3%
How do you feel that you interact with friends and family while working night duty?	as well as usual	67.9%	40.2%	16.8%
	not as well as usual	32.1%	59.8%	83.0%
Do you feel physically comfortable while working nights?	yes	96.4%	69.2%	52.9%
	no	3.6%	30.8%	47.1%
Do you feel that your reflexes are	quick	78.5%	46.7%	28.9%
	jumpy	10.1%	20.7%	29.2%
	slowed somewhat	11.4%	30.4%	40.0%
	slowed considerably	—	2.2%	1.9%
Working nights, do you generally feel	bored	2.5%	7.0%	13.4%
	lethargic	4.9%	36.0%	43.6%
	content	87.7%	47.7%	21.8%
	anxious	4.9%	9.3%	20.0%
When you return home after a night shift do you generally feel	cheerful	25.6%	18.0%	8.5%
	content	72.0%	57.3%	46.5%
	letdown	2.4%	24.7%	44.5%

well to the demands made upon them during the night shift, regardless of whether or not they feel physically comfortable working at this time.

The majority of nurses responding say that they feel alert most of the time during the night, although 1/3 of those nurses working nights out of necessity feel alert only some of the time and 3.8% do not feel alert at all (a small percentage, but a sobering thought).

"I am not alert; only tense and nervous."

"I worry about the patients in my care, even though I know it's silly. When I sleep, I dream about them, and about being at work."

Most nurses describe their thinking processes as at least adequate, regardless of their motivation for working nights. Again, it may be important to consider the minority of nurses who feel that their thinking is impaired when they work nights — only 1.2% of voluntary night workers, but 13.4% of the greater percentage of those working nights, the involuntary night workers.

"At night, I always want to ask another nurse for an opinion for simple things — on days, I can rely on myself."

"I do dumb things at night — I'm always losing things. I feel incompetent."

"I have to fight being over-excited or the feeling takes over, and I'm not thinking straight."

Everyday activities

Aside from the physiological problems arising from living 'upside-down', regulating living around night duty can be very frustrating to many nurses. Working, only part of the whole of any person's experience, sometimes seems to dominate and frustrate other activities during a term of night shift.

Even those nurses who prefer nights seem to have problems with making time for shopping, banking and related activities, with 50.2% of this group complaining of some degree of difficulty in fulfilling these tasks. In other groups, the difficulties seem even more pronounced.

"My chores all get done ... but it's because I just can't sleep."

"I find it hard to get anything done in my home when I work nights, and my days after nights are a complete loss until my system swings around again (sometimes a whole week)."

"It takes me three to five days to feel normal and rested again, and once I'm readjusted, I feel like I have to catch up on so many things."

There are nurses who feel that night duty does not interfere with their everyday relationships with others.

"It's the best of two worlds — I can do what I want in the daytime, and I'm available to my children when they need me most."

"I can sleep all day, have a pleasant evening with my friends and then go to work."

But generally interaction with family and friends seems to suffer from the demands imposed by working nights — 32.1% of those who prefer night shift complain that they do not interact as well as usual with friends and family while they are working nights. This percentage grows to an overwhelming 83% for those who work nights because of hospital policy.

"The family always suffers ..."

"A lot of nurses seem to have family problems — shift work with all its demands could be at the bottom of it."

"When I work nights, I never get in touch with my friends ... I feel that no time is my time ... I'm just so irritable."

"Getting on the bus to go to work at night, I feel really out of touch with the rest of society."

"Night duty is like hibernating — I'm so out of touch with everybody!"

Depending on how important we consider these relationships, this evidence seems to be a strong point in favor of keeping night shift rotations short. How important are these relationships in our lives? How important is our work ... Need the two conflict?

Mood

"Night shift that winter was a low point in my life. My biggest problem was depression in my off duty hours and inability to relate to those I care for most — my husband and two school-age sons. I've never had so little confidence in myself, so little self-esteem."

For some nurses, night shift rolls around once every three weeks. If it is accompanied by physiological discomfort and a feeling of alienation from the rest of the world, it can be a miserable experience.

Working nights, how do you generally feel? Of those preferring nights, 87.7% said that they felt content through the night, and only 12.3% termed themselves bored, lethargic, or anxious. Again, those working nights because of hospital policy had markedly different answers — 21.8% called themselves content; 13.4%, bored; 43.6%, lethargic; 20.0%, anxious.

52.6% of these workers also called themselves either slightly depressed or miserable in answer to another 'mood' question. And 68.3% said that they felt 'slightly low' or 'depressed' in their off duty hours. All of these answers contrast sharply with answers given by those who prefer night duty. Those working nights because of hospital policy indicated that they had rapid mood swings, felt alienated, or just tired and irritable.

Although the majority of night workers in both groups indicated that they felt that their night functions were necessary and worthwhile, job satisfaction does not seem to have tipped the balance or led those nurses who must work nights to feel really good about it. So let's look at what voluntary night workers find rewarding about night duty, and what makes night duty impossible for others.

The pros and cons

Most nurses who said they prefer night duty mentioned independence and enhanced nurse-patient communicaton as the greatest advantages to night work.

"I work better alone, away from the rat race of day shift." "Night shift brings both challenge and responsibility, more time for patient care and the emotional support that no one has time to give on other shifts."

"It gives you a different perspective on patient problems." "I have a great sense of responsibility and well-being when I work nights." "On nights there is less hustle and bustle, no housekeeping staff, technicians or doctors to trip over. Generally the atmosphere is relaxed with other nurses, supervisors and doctors, and there is a kind of 'esprit de corps' not found on other shifts."

"Night duty provides me with a time to take stock of myself as a nurse, and as a person."

If night shift work is, as one nurse put it "not to be looked upon as an imposition, but as part of our role as nurses," then these nurses are fortunate in viewing their night shift experience in a positive light. Another nurse says, "If we eat and sleep well, we should function as well as day workers...," but there are indications that some nurses find it impossible to eat or sleep well. They walk "a metabolic tightrope" and therefore find it impossible to describe night shift in anything but grim terms.

"I can't comprehend that there are nurses who prefer night shift — I start dreading nights for three or four days before I start my tour of night work."

"It takes me a full week to recover my balance after working nights ... and that means eating, sleeping, and emotional balance. It's worse than jet lag."

"Normally I feel very alive, very buoyant. I'm a different person when I have to work nights."

"Normally I love to work and I enjoy my free time too. On nights I only work, sleep (or try to) and I can't eat."

"The older I get, the harder it gets — not the work itself, but acclimatizing my body to night living and day sleeping."

"I have actually cried before going on night duty — once I get to work it's not quite so bad, but I don't function well."

"Learning and meeting people is essential to me. On nights I am restless, depressed and think about leaving a job I love — nursing."

"It's hard on my health. No matter how I try to call it mind over matter, my body, my mind, my emotional well-being, all of me feels in limbo. I feel less than a whole person. Night shift literally makes me ill."

It seems that here we have our stumbling block. Is it mind over matter that makes some nurses see the positive and make the best of a "necessary evil," while others lack the moral fibre to fulfill an obligation cheerfully? It doesn't really seem so — there is current evidence that individuals adapt very differently to changes in their daily physiological patterns, that for

some, the shift from days to nights poses genuine and serious problems in biological response, well-being, and efficiency (see Circadian Rhythms).

So many times, the time-sheet or Master Rotation Plan reflects little consideration for individuals, individuals who are so much more than just workers. Granted, making out time-sheets is no easy proposition. So perhaps our first step in overcoming the problem of shift work is to look at what is going on, evaluate it, and explore other possibilities. Night work, as evening shift, day work, and weekend duty, is part of nursing. But, as one nurse put it, the problem needs some "good hard thinking."

On Circadian Rhythms

As one very understanding (and enthusiastic) night nurse put it, "For people who have problems changing their sleeping patterns, the night shift is misery — it shows on their faces, in their temperaments, and in their ability to react to any kind of stressful situation."

Studies on circadian (24-hour) rhythms may lend "morning types" a little insight into how night owls manage to view night shift in a positive light. These studies have shown that certain individuals can adapt more readily to radical changes in their sleeping-waking patterns than others. Many of our bodily functions — sleep/wakefulness, hunger, hormonal balance, renal flow, temperature, mental and physical ability — move in a daily cycle,[1] as surely as light and dark. The 'chilly' feeling that many of our respondents noted at about four A.M. coincides with evidence from studies that show that a typical oral temperature peaks at about 20:00 hours and ebbs in the vicinity of 04:00 hours.[2]

Ostberg has reported a significant difference between the maximum temperature of those individuals who are "morning types" and those who call themselves "evening types." He found that those individuals whose oral temperature peaks the soonest (the "morning types") tend to have the greatest difficulty adjusting to radical changes in hours.[3] Not surprisingly then, those nurses who cited a specific time when they had difficulty just staying awake on night duty, specified the time period between four and six A.M.

Studies have also indicated that performance tests done in the middle of the night yield consistently poorer scores than those done at midday (regardless of how well-rested the individual tested may be).[4] One author suggests that perhaps it is because of our rhythms that we sleep at night, when we are least efficient, during the depressed phase of our circadian cycle.[5]

Exploring the Possibilities

On permanent shifts

Permanent shift tends to evoke strong reactions from many nurses, both positive and negative. On the negative side, nurses will argue that it cuts a nurse off from a 24-hour view of patient care, that permanent shift workers become inflexible slaves to their own little routines, that they are difficult for head nurses to evaluate.

On the other hand, many nurses expressed the following feelings:

"If a nurse prefers to work permanent nights, she gets the argument that it would be just too difficult to work out, that it's favoritism, or contrary to hospital policy. Why? Perhaps this nurse functions better at night, perhaps she would be a better nurse if she were allowed to adjust her working and home life into a stable pattern."

In 1970, Helen Saunders wrote a convincing argument in favor of permanent shifts,[6] outlining administrative advantages, advantages to the nurse, and most important, to the patient. Her opinions are something to think about:

"Permanent shift can have social, educational, psychological and health advantages for the nurse.

"To begin, the nurse would be able to choose the shift that best fits her personal and family life. She would be able to take part in sports groups or teams, hobby groups, community organizations, church activities, professional association work — in fact in all social activities ... It is impossible to keep up many social activities while on a continually rotating shift."

She goes on to mention the advantages of family stability, educational possibilities, and adds "One basic rule of health is to maintain regular hours for sleeping and eating ... studies show we can adapt to other patterns ... provided we are given the time needed to adapt and provided the patterns are constant."

Administration, she says, can gain from the experience of a permanent shift worker, and the patient is assured of an alert nurse and continuity of care.

Saunders adds that permanency of shift must be tempered with common sense, that thorough orientation, and short periods on alternate shifts are necessary to keep the nurse in tune with what goes on on a 24-hour basis.

Permanent shift is certainly not everyone's answer. Is there room in our organizations for allowing some nurses to work a shift of preference while others rotate shifts? Is permanent shift, opinions aside, measurably beneficial to those concerned with patient care? Permanent shift work is nothing new. Has its effectiveness — for the nurse, for the patient, for the hospital, — ever been fully evaluated?

Two shifts — better than three?

"Working three shifts amounts to exploitation — it is both unhealthy and unnecessarily hard on everyone."

"I really don't understand why it should be compulsory to work all three shifts. Days should be compulsory — just to keep up with what's going on — but there is no reason there can't be a choice between evenings and nights."

"Why are two-shift rotations denied at our hospital? I know it works for some hospitals, so why not here? Adjustment to the rotation of hours takes time, and rapid rotation on three shifts certainly makes me wonder about my efficiency as a nurse."

A number of respondents to our questionnaire suggested that the two shift rotation would be a vast improvement over the three shift system. Many mentioned that it would be most acceptable to the greater number of nurses because it would cause less disturbance to them and to their families and would allow them to function better at work and at home.

It appears from the responses that there are hospitals that use the two shift system, so that the argument that it is impossible doesn't really seem to hold water. Perhaps it is another possibility for us to consider.

The long and short of it

There are other approaches to consider when looking at shift work. One has to do with the length of time that a nurse should work a particular shift. Is seven days of night duty in one period too long or too short? Are twelve-hour shifts a viable alternative to longer stretches of duty on three shifts?

"Only once have I enjoyed nights — and that was on a four-week rotation of nights. This allowed me to adjust to shift hours — a workable eating, sleeping and recreation pattern was easy to establish before another change.

We were a warm, congenial group, because staff were well-rested and alert. Care was more patient-oriented. After those nights, I realized that seven-day adjustments (the rotation plan used in so many settings) were the worst for me. My personality and decision-making ability were really affected by all the changing around."

"I have worked rapid rotation shift for 10 years, and still have problems adjusting. Maybe longer periods on one shift would be better."

Studies done in industry where shift work is also necessary have not yet established whether or not longer stretches of a particular shift are generally advantageous. It has been proposed that two or three-day stretches of shift may interfere less with adaptation to shift work.[7] The important recommendation that such studies make is that there is scope for further research, that shift work in industry, though widespread, has not been evaluated, and needs further study.

"Seven nights is taxing, too long. By the sixth or seventh night, I'm exhausted, impatient, uncaring, and despondent. Fatigue for me means emotional and physical imbalance. Five nights is enough at one stretch for me to be able to cope with any complexities or emergencies at a time when hospital staffing is at its minimum."

The past few years have seen some experimentaton with a return to the use of the 12-hour shift; reactions to this system are mixed.

"Twelve-hour shifts help tremendously. You know your patients before the lights go out and they know you."

"Twelve-hour nights — such a long time to work without becoming tired, frustrated and angry."

Permanent shift, two shift rotations, blocks of shift, rapid rotation, and twelve-hour shifts — by now you may have begun to recognize some of the problems faced by those who wrestle with time sheets. Some would argue that no arrangement is going to please every nurse, that compulsory three rotation shift is the only expedient way to ensure patient care on a 24-hour basis.

Our questionnaire does not pretend scientific status; we have instead tried to focus on your feelings about an area of concern to all of us. How much weight can we give to all your opinions? Strong arguments seem to come from all sides. But if we return to our "good hard thinking," we recognize that more acceptable solutions to the problems of shift work require knowledge, planning, trial and evaluation rather than a habitual or haphazard approach.

Nursing literature doesn't seem to have a great deal to offer in an area so fundamental to nursing. Perhaps it's time all of us took a good long look at shift work, at how it affects us, and weighed the pros and cons of alternatives to whatever systems we now use.

As one of our respondents writes: "Why should we break down our health simply to hold down a job. Nursing means something to me — it's much more than just a job — but I drag through night shift, and the rewards of nursing disappear.

"What nursing needs is more flexibility. Why is shift handled in such a dictatorial way? Is there a better way? I feel that we need some freedom to choose our working hours, those hours when we can function well, realize our value and recognize all the potential of our personal lives."

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Listening *does* help:

ONE PATIENT'S EXPERIENCE

Mona Winberg is disabled by cerebral palsy. In spite of her handicap, Mona lives alone. Cerebral palsy is crippling (both physically and emotionally) but many afflicted people can manage on their own and do want to be independent. In this article Mona shares with us her fears and apprehensions during her first visit to hospital and she tells us how patient and understanding nurses, both at home and in the hospital, helped her along the road to recovery.

Talking is one of Mona's favorite pastimes (by her own admission). She is seen here chatting with a former board member of the Adult Cerebral Palsy Institute of Metropolitan Toronto at Bellwoods Park House annual garden party. Bellwoods is Canada's first residenc for disabled adults.

Mona Winberg
Joan Hobson

Not long ago I entered North York General Hospital in Toronto for a Dilatation and Curettage. Unfortunately, the "D & C" showed that a hysterectomy was necessary and the three days that I was originally scheduled to spend in hospital stretched into a seemingly endless six and a half weeks, including a stay in a convalescent hospital.

As is usual, with any new experience, both fear and apprehension overwhelmed me. How would the nurses and other staff react to having a cerebral palsied person as a patient? What would my roommate be like? Would I be able to cope as independently in the hospital as I do at home?

I am disabled by cerebral palsy. It affects mainly my hands, which are not able to function in a coordinated manner; and my speech, which although comprehensible is accompanied by involuntary jerkiness.

Happily all of my fears about entering the hospital proved groundless. The nurses were friendly, compassionate people and I was soon on a greeting and smiling basis with all of the hospital staff.

My roommate's name was Edith. She entered the hospital a couple of days after me for the same operation. She knew all about cerebral palsy as she has a niece who is similarly disabled. Edith was remarkably helpful and understanding. But let's go back a little, for all of that is the end of my story.

Pre-op

The fun began as soon as I was admitted. The nurses needed a blood sample. They tried three times (once when I was mildly sedated) and three times I tensed up and no blood would flow!

Finally, the night before the operation, three nurses marched into my room and announced with determination: "We're not leaving without your blood." Two nurses distracted me with conversation (which is always a good device to use with me) while the other plunged a needle into my already black and blue arm. Hallelujah! At last they were able to get the blood they needed.

My last medical interview, before the operation, was with the anesthetist who said:"Usually I try to fit the intravenous needle into my patient's arm before the operation. But, in your case, I think I had better wait until you are under anesthetic."

After my experience with the blood sample, I most heartily agreed with him.

The last thing I remember before the operation is drowsily asking the anesthetist why they made operating room tables so narrow. He replied laughingly: "To allow fat doctors to get around them."

Post-op

The following week is still a rather hazy memory for me. I developed a temperature and a cough and so I was kept on intravenous therapy for a few days longer than usual. But that was the least of my worries for as the sedation gradually wore off, I was faced with a far more dismal problem. My coordination, or whatever I had of it, seemed to have completely deserted me.

In vain the doctors, nurses and my family tried to reassure me. They told me this was just a temporary state of affairs due to after-effects of the operation. They told me not to worry — but I was desolate and could not be consoled. The nights found me thinking thoughts as black as the sky outside for where could I go and what would I do if I could no longer take care of myself? Which institutions, even the ones who were geared for it, would want to accept somebody who could do so little for herself?

I remember lying in bed one night, unable to sleep. The night nurse came in and we talked together for awhile. We didn't talk for long — it was just fifteen minutes or so. What we talked about does not matter; what is important is that this nurse, through her understanding interest and sincere solicitude relaxed me and made me feel more courageous than I'd felt in weeks.

This episode marked a real turning point in my recovery. My coordination gradually returned. No conqueror of Mount Everest could have felt more jubilant than I when I discovered I could once again feed myself.

One day, two student nurses came in and said they'd help me take a tub bath if I wanted to have one. I was more than willing to go with them and the bath felt great. Afterwards however we all agreed on one thing: hospital bathrooms are not designed to accommodate three people.

The day soon came when my gynecologist told me he thought I was ready to be moved to St. John's Convalescent Hospital. I was glad my recovery had progressed that far but I was still worried. St. John's would be yet another new place with new faces and new situations to cope with.

I was very sad when the time came to say good-bye to Edith — we had travelled the same difficult road together. As for the nurses, I shall always think of them with affection and gratitude. Their understanding and encouragement helped pull me through one of the most demanding periods of my life.



Convalescence

I was made to feel most welcome at St. John's. My admitting nurse was the mother-in-law of an active Board Member of the Ontario Federation for the Cerebral Palsied so she understood my situation very well. My new roommate, Ruth, greeted me cheerfully; she was a friendly and outgoing person.

If the treatment I received at St. John's had to be summed up in three words they would have to be: tender, loving care. The atmosphere there was so relaxed and restful that both my sleep and my appetite improved greatly. After two weeks, my family physician told me I was ready to go home. As I was wheeled down the corridors to the door, the nurses and other patients either called or waved their good-byes.

So, at long last, there I was, ... home — a little shaky and a few pounds lighter — but back in my own little apartment. Nothing has ever looked so good to me.

Despite all of the physical discomfort and mental anguish, I feel the time I spent in the hospital was a most worthwhile learning experience. It taught me that even though disabled people may have to work a little harder at gaining acceptance, the understanding and warmth that one receives in return makes any effort well rewarded.

CNJ asked author **Mona Winberg** to tell us a little about herself. This is what she had to say.

"When I was young I attended a special public school for handicapped children in Toronto. Later I enrolled at the High School of Commerce and upon graduation completed one year at the University of Toronto.

After leaving university I worked in the bookkeeping department of Corbrook Sheltered Workshop for six years. I was editor of "Contact," the national publication of the Canadian Cerebral Palsy Association, for the next five years.

Right now, I am second vice-president of the Adult Cerebral Palsy Institute of Metropolitan Toronto. The Institute is the operating body of Bellwoods Park House, Canada's first residence for disabled adults. Bellwoods is celebrating its 10th Anniversary this year. I am also Chairman of Bellwoods' New Directions Committee. The purpose of our committee is to establish and define new priorities for Bellwoods and its residents.

As a past president of the Ontario Federation for the Cerebral Palsied I have worked for some time now in an effort to establish apartment accommodation, with special support services, for disabled adults. I believe it is essential that we be able to provide handicapped people with their own choice of living accommodation, whether it be residence, group home or apartment.

But what is most important is that I have been blessed with a wonderful family and friends; through their special confidence in me these people have given me the courage to try new ventures without fear of being alone."

Joan Hobson, VON

Thanks to supportive hospital staff Mona found her hospital experience most agreeable. She is now feeling very well and living independently in her "own little apartment."

As Mona's visiting nurse I resumed my weekly visits to her as soon as she returned home. What can I, as a nurse in the community, do to help those with cerebral palsy manage on their own? Together, Mona and I drew up this guide:

- **It is important for the community nurse to realize that she is not just dispensing medical treatment or counseling in health concerns. During her visits to the home, the nurse should listen, encourage, support and share — both in the laughter and the disappointments.**
- **The nurse can assist by discussing the available community services. But she should always remember that the cerebral palsied person is as much an individual with her own preferred lifestyle as any other person; she must allow her patient the dignity and freedom of choosing her own way of life.**
- **Since the community nurse may be the only person her cerebral palsied client sees all day, it is of inestimable value if the nurse patiently takes the time to make herself aware of any other service that she could perform. This could be just little things that the cerebral palsied person, because of her disability, cannot do for herself. A nurse has to be realistic and understand that many persons with cerebral palsy, no matter how much they may wish to be independent, cannot manage without some supportive care or service.**

In conclusion, perhaps my entire philosophy when dealing with a handicapped client can be summed up this way:
I have learned it is essential that the community nurse look upon the person with cerebral palsy not as a helpless individual, but as a human being of worth and dignity. This person is struggling to make a life for herself in the community. The visiting nurse is in a unique position because she has the potential to make this road a great deal easier and freer of obstacles.

Joan Hobson *is a graduate of the Wellesley Hospital school of nursing in Toronto. She has received diplomas in Teaching and Supervision from the University of Western Ontario and Public Health Nursing from the University of Toronto. Right now she is on the nursing staff of the Victorian Order of Nurses, Metro Toronto Branch.*

HELPING A FAMILY AND THEIR PREMATURE BABY GROW TOGETHER



Interaction between a mother and her premature infant is all too often discouraged by the glass barrier of the premature nursery, a barrier that protects the baby when he is most vulnerable, but may signify to his mother that he is fragile, untouchable. Studies have shown us that communication between a mother and her child is vital during the first few days of a baby's life, that it shapes responses between mother and child for years to come. A sensitive and knowledgeable nurse can play an important role in bringing a mother, father and their premature infant together, helping them to discover one another, and easing the development of a bond between them in spite of the glass barrier.

"Elizabeth was born six weeks prematurely in an unfamiliar hospital. My husband was out of town. At first, the whole experience was very frightening for me.

"It was a nurse that helped me to get over my fear and get to know my new baby. Her help allowed me to come to terms with the grieving I felt as I anticipated the possible loss of the baby. When Elizabeth was born, the nurse explained to me with sensitivity the need for special nursing care and the equipment involved in the treatment of my premature child. I learned to trust this nurse. She encouraged me to touch Elizabeth in her incubator just a few hours after she was born, and to change her diaper on the following day.

"When my husband arrived, we talked to the nurse together, expressing all our fears about Elizabeth's tiny size, her treatment and expected development. As the days passed and our baby's health improved, we were encouraged to spend more time with her, feeding her and holding her. Because of our involvement with Elizabeth, we came to realize how normal she was.

"I breast-fed Elizabeth twice a day before she came home. I learned to be patient... not to panic at my daughter's immature sucking reflex. The nurse helped me to realize that the problems I had feeding Elizabeth were not a reflection on my ability to mother, and that with patience on my part, the baby would drink adequately. Because of her interest, knowledge and empathy, this nurse became a link that drew us closer to our daughter during an emotional period."

Norma J. Murphy



It was the story of my friend that helped me to realize just how helpful a nurse can be in bringing a new mother and father and their premature infant together.

A number of factors influence the depth and intensity of the attachment that eventually develops between parents and their newborn child. People who are about to become parents take on roles that command new responsibilities and behavior patterns; their response is determined in part by their upbringing and their backgrounds, and, in turn, influences the degree to which they can become close to their child.

A mother's attitude towards her baby is shaped by the way she accepts her pregnancy and by her perception of the unborn child as an individual. The birth of the baby and the mother's first experience seeing and caring for the child also have an important effect on her initial response to him. Recently it has been acknowledged that the contact of mother and child in the first few hours and days of the child's life have an extremely important influence on the quality and lasting effect of the bond between them.

In the case of a premature birth, the immediate nature of mother-child bonding can meet with interference. When a child is born prematurely, the mother may be separated from him shortly after his birth, and so she has little opportunity to interact with him or provide his basic care at this time. This imposed alienation affects both mother and child and, as a result, the mother of a premature child may have a distorted perception of her infant that can have serious results for the bond between them. Understanding what is known about mother-child bonding, in order that we may facilitate its development when a premature birth makes separation inevitable, is a step in the direction of helping these families.

Understanding Maternal-Child Bonding

The first minutes and days after the birth of a baby constitute a maternal sensitive period. During this time mother and child become actively involved in behaviors that complement and reward. Bonding at the sensory level draws the mother and child together with great interest, dependence and commitment.

The observations of a number of authors allow us to see what happens in the bonding process, how interactions between the mother and child begin. The mother will begin to recognize her infant as an individual apart from herself as she initially explores the baby and notices his reactions to his new environment. The mother and child begin bonding through the sense of touch. Initially, the mother examines her child with her fingertips, then with her palms, while making eye-to-eye contact with the baby.

Immediately after he is born, the infant is in a quiet, alert state, with his eyes open for 45 to 60 minutes.[1] The infant can see and has visual preferences. It is not long before he focuses on the most interesting visual stimulus — the human eye.

At birth, the infant moves his head when he is spoken to; because of a sensitive auditory perception he will respond to a high-pitched female voice in preference to a male voice. The neonate also moves to the rhythm of human speech — as the speaker pauses for a breath, he almost imperceptibly raises his eyebrow or lowers his foot.

In utero, the actions and rhythms of the fetus are strongly influenced by his mother. Birth interferes with these actions and rhythms and the infant must adapt to a new environment. The mother helps her infant to reestablish biorhythmicity. Progressively, the infant grows more alert during those times when he is being held by his mother. His cry produces physiological changes in the mother that encourage her to feed him. On the fifth day of life, it has been noted that breast-feeding infants are able to discriminate the smell of their mother from that of another mother with significant reliability.[2] Many mothers observe that their baby has a particular scent.

It can be seen from the observations recorded about the bonding process that the first few days of life elicit mother-child closeness. What are the effects on this closeness when a premature infant is immediately hurried to an intensive care unit or to another hospital where he is cared for exclusively by skilled nurses, and the mother doesn't have a chance to be with him?



The Effects of Separation

The mother of a premature infant often experiences the child's birth as an emotional crisis involving strong guilt feelings. Resolution of her conflicting feelings is essential so that she and her baby may develop closeness to one another. According to Kaplan and Mason, there are four tasks that must be mastered by the mother of a premature infant in order to promote a close relationship between her and her child.[3]

The first task confronts her at the time of the baby's birth. At this time, the mother prepares for the possible loss of her baby by withdrawing from the relationship; she hopes for her child's survival but simultaneously prepares herself for his death. Secondly, when the child is born, she must face the fact that her baby is not full term — she must give up her dream baby and face the reality that her child is premature. The third task involves changing her attitude as improvement in her baby becomes apparent. Finally, she must learn the differences between a normal infant and her premature child in order to respond appropriately as she learns to care for him. Failure to cope with any of these four tasks is seen as detrimental to the mother-child attachment.

The parents of a sick premature baby may feel that the child is not really theirs, even when he is discharged from the hospital to become part of the family. Although the baby's problems are entirely resolved prior to his discharge from hospital, his mother's behavior may often be disturbed during the first year or more of her infant's life. An increase in the incidence of failure to thrive without organic cause and in cases of battered child syndrome has also been shown among premature infants and those hospitalized in the newborn period (that is, in comparison with those who were not separated from their mother during this period of time).[4]



The Role of the Neonatal Nurse

The nurse in a neonatal unit can assume a great deal of responsibility for preventing the development of physical, emotional and social problems for the parents and their child. By encouraging parents to explore together and eventually accept their feelings about the baby, she can help them to become closer to their child. She can help to reduce the number and intensity of parental concerns by teaching parents about the behavior of their premature baby and about basic care of the child. Emphasis should be placed on teaching the parents about immature behavior which could seem threatening to a mother and add to her feelings of inadequacy, for example, the child's poor sucking reflex or special problems such as heat control or apneic spells.

The nurse can assess the parents' emotional response to their infant by observing their efforts to touch the baby, to learn about him, or take part in his care. She can also observe the way in which the couple share their positive and negative feelings, and discuss their preparations and plans for caring for the baby at home. In this way she can do a great deal to facilitate the mother-child bonding process and the development of a healthy relationship between them.

In order to be an effective link between the mother and child, the nurse must be aware of her own feelings and ideas about her role as a neonatal nurse. Self-awareness and communication skills are important for they enable her to be sensitive to the needs of each individual family. Sometimes a group approach that includes a social worker or chaplain along with the nurse can be most helpful to the family of a premature infant.

The Glass Barrier

There are a number of problems apparent for the nurse concerned with quality care in neonatal nursing, problems associated particularly with the care of premature newborns. Some of these barriers need to be overcome in order to promote helpful relationships between the nurse and families of premature infants.

- *Inadequate staffing*

Neonatal nurses are often discouraged because of the problems arising from inadequate staffing. So often there is little time to give the comprehensive and understanding care necessary to encourage a mother to get to know her baby. A new mother may be frightened, for example, to hold her infant while he is receiving oxygen unless a nurse is present. But it is almost impossible for a nurse who is caring for five sick infants to spend time with each individual mother. A one-to-one nurse/patient ratio would allow the nurse to be fully responsible for the infant throughout his hospitalization and consequently deliver better nursing care to the infant and continual support to the child's parents.

- *Unit structure*

Very often, the physical structure of the neonatal unit is not conducive to the development of a close mother-child relationship. A mother needs the privacy of a parents' room for examining, holding and breast-feeding her baby. Ideally, the parents' room would be furnished to allow the involvement of the baby's father and other family members. Such a unit should be as relaxing a setting as possible, with dimmed lights, a rocking chair, colors and music to counteract the hospital atmosphere and stimulate the infant. Facilities should be available for a mother to remain in the hospital with her child, especially if the family lives in an area outside of the hospital center.

- *'Don't touch'*

Often the parents' fear and anxiety is exaggerated in the neonatal unit by the busyness of skilled nurses, noisy machinery and emergencies. Sometimes a nurse may forget that a setting so familiar to her may cause parents considerable anxiety, and she may make little effort to allay their fears.

If a neonatal nurse examines her behavior carefully, she may have to admit to the attitude that the nursery is her domain, that she resents the involvement of parents because it threatens to down-play her own importance. The 'don't touch' attitude of many nurses tends to add to the parents' sense of uneasiness.

How do we change our attitude? Perhaps if nurses are given the time and are encouraged to share in teaching parents about their premature infant, they would find the rewards of involvement the motivating force necessary for change of attitude.



- *Education*

The neonatal nurse requires formal training in the specific physical needs of the premature baby, and in the emotional needs of the parents. Such education should emphasize communication skills and the need for self-awareness. Knowledge of communication skills can help the nurse to relate her interest in the family without seeming to intrude on the integrity of the family members involved, without seeming to interfere with their ways of coping. By learning to listen to a mother talk about preparations for the baby's homecoming, for example, she will be able to understand whether or not the mother feels confident. By helping a mother to recognize and accept her feelings, she is in a position to help her work out a solution.

- *Family Involvement*

If nursing care is to be family centered, consideration must be given to family members at home who may know very little about the baby's hospitalization. The child left at home needs to know why his parents are spending so much time at the hospital. Unless parents take the time to talk to the child at home, he may arrive at his own conclusions about the baby's stay in hospital, conclusions that could be inaccurate and troublesome to him. Parents should be made alert to changes in a child's playing, eating and sleeping habits that might indicate his need to express himself openly. If the child is shown pictures of the baby and assurance that the baby will "grow up" it helps him prepare for a new family member.



• *Involvement of Others*

Parents of premature infants need the involvement of their friends as well as professionals. Talking to other parents or friends often helps the parents of a premature baby see their situation in perspective. Nurses are in a key position to help bring parents together with others to share their experiences.

The initial phase of mother-child bonding significantly affects the development of a child. What could be more important to the well-being of family life than our efforts to promote this early attachment? As nurses, we are in a key position to provide vital opportunities for mother-child bonding. When parents are separated from their newborn infant, as in a premature birth, it is important that we take initiative in helping mother and father become acquainted with the baby.



Norma J. Murphy *(R.N., Halifax Infirmary School of Nursing, B.N., Dalhousie University, Halifax, Nova Scotia) has had most of her nursing experience in the field of pediatrics, including neonatal intensive care. In August of this year, she joined the College of Nursing of the University of Saskatchewan, Saskatoon, as a teacher of psychiatric nursing.*

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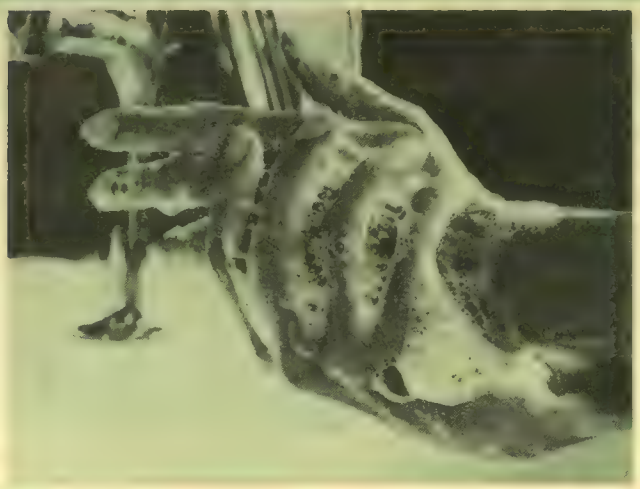
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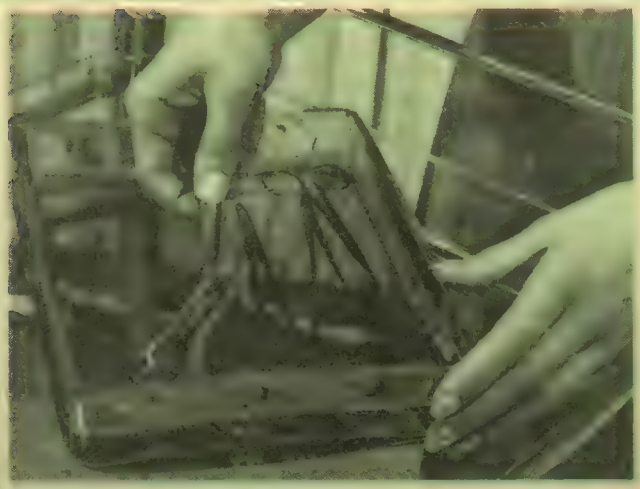
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Names and Faces

Canadian Nurses Foundation Scholars

Thirteen Canadian nurses have been granted scholarships from the Canadian Nurses Foundation for the academic year 1977-1978. This year, a total of $9,000 was awarded for doctoral studies related to nursing and $24,500 for study at the Master's level.

The Canadian Nurses Foundation was established in 1962 by the Canadian Nurses Association to receive funds and administer fellowships for the preparation of nurses for leadership positions. A total of 144 nurses have been awarded scholarships under the program to date. CNF funding is voluntary and dependent on gifts, donations and bequests from individuals and organizations.

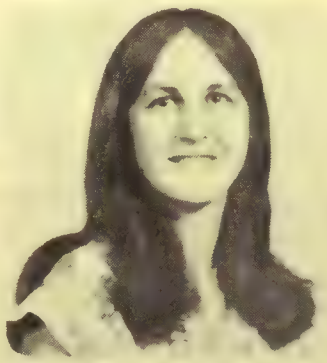
Jenniece Beryl Larsen, a former nursing instructor at Grant MacEwan Community College in Edmonton, has been awarded the Katherine E. MacLaggan Fellowship of $4,500 to continue her doctoral studies in educational administration at the University of Alberta. Upon completion of her degree, Larsen plans to teach nursing at either the university or community college level and/or obtain a government position involving organization and planning in the field of health and welfare in Canada.



Heather Marion Ogilvie, presently the co-ordinator of education and research at the Children's Hospital of Eastern Ontario in Ottawa, has been awarded $4,500 to begin doctoral studies in child health at Texas Woman's University in Houston, Texas. Following completion of her doctoral studies, Ogilvie plans to continue in the area of research in child health.

Jane Buchan of Vancouver has been named winner of the White Sister's Uniforms Incorporated Scholarship Award of $1,000 and a CNF award of $2,000. She will enter her final year at the University of British Columbia where she has been studying community nursing at the Master's level. This is the second year that Buchan has been awarded a CNF scholarship.

Marilyn Darlene Botterill of Edmonton, Alberta will receive $3,000 to begin Master's study in nursing at the University of Alberta with special emphasis on critical care in nursing practice. Formerly, she held a postiion with the Department of Health and Social Development for the province of Manitoba and has nursed in a newborn intensive care unit in Winnipeg. Botterill is keenly interested in research and hopes to complete doctoral requirements following her Master's degree.



Dawn Marie Hanson of St. John's, Newfoundland will receive a $3,000 scholarship and plans to begin Master's study in counseling in mental health at the University of Oregon in Eugene, Oregon. Hanson's particular interest is in the area of community mental health and upon completion of her degree, she plans to practice counseling in mental health in Newfoundland and to teach at the university level.

Sheryl Ann Lapp of Winnipeg, Manitoba has been awarded the Helen McArthur Canadian Red Cross Fellowship for Graduate Studies in the amount of $3,500. She will begin study towards a Master's degree in community health nursing at the University of Minnesota, in Minneapolis, Minnesota. Lapp plans to return to the University of Manitoba School of Nursing following completion of her degree.



Wendy Lynn McKnight, of Ottawa will receive $2,000 to complete her second and final year in a Master's program at McGill University in Montreal where she has been examining family involvement in emergency room care nursing. This is the second year she has received a CNF scholarship. Following completion of her Master's degree, McKnight plans to find a position as a clinical specialist in an emergency department of a hospital.



Kiyoko Matsuno of Montreal will receive a $3,000 scholarship and plans to complete Master's study in clinical nursing at McGill University, Montreal. Her background includes nursing of children, psychiatric nursing and neuro-psychiatry. Previously, she spent a year as a nurse consultant in Osaka, Japan. Matsuno plans to continue in the field of psychiatric nursing when she completes her studies.



Isabel Caroline Milton of Beaconsfield, Quebec will receive a $3,000 scholarship and plans to complete a Master's degree in community nursing at McGill University. Upon completion of her degree, Milton plans to practice in a community health center in the Montreal area and hopes eventually t teach nursing at the community college or university level.



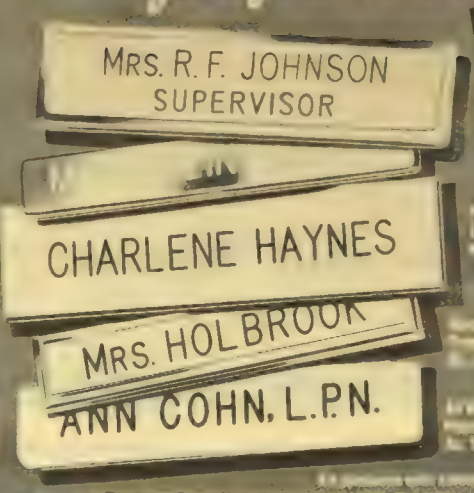
Eleanor Grace Pask of Toront will receive a $1,100 scholarship to study at the University of Toronto towards a Master's degree in materna and child health. Pask's nursing experience includes nursing children in various hospital settings in both the U.S. and Canada.

Laurie Dawn Reid of Edmonton Alberta will receive a $3,000 scholarship and plans to enter the Master's program at the University of Toronto to study community health nursing. Reid plans to teach community health nursing in a Canadian university following completion of her studies.

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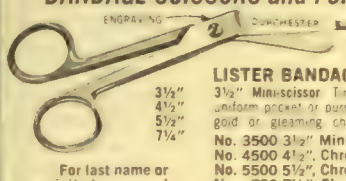
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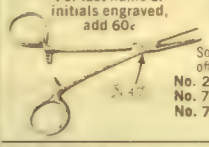
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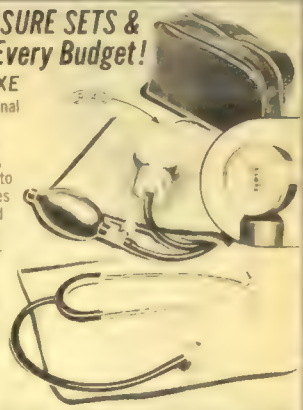
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Names and Faces



Ingeburg Ursula Schamborzki of the Town of Mount Royal, Quebec will receive a $1,000 scholarship and plans to enter the Master's program in nursing at McGill University to specialize in research in nursing and health care. Recently she was the co-ordinator of inservice education at the Montreal General Hospital. Her future goals include pursuing a career in administration or as a nurse clinican.

Joan Irene Wearing of Montreal has been awarded a $3,000 scholarship to enter the Master's program in nursing at the University of British Columbia where she will examine primary health care as it relates to the elderly. Upon completion of her degree, Wearing plans to resume work in a primary care setting.

Olive E. Anstey, of Australia was elected president of the International Council of Nurses at the 16th Quadrennial Congress held recently in Japan. She will head the world-wide organization of more than one million nurses from 88 countries until the next Congress in 1981. She succeeds Dorothy Cornelius from the United States.

Anstey is a former president and senior vice-president of the Royal Australian Nursing Federation and has been a member of the ICN Board since 1973. She is well-known throughout Australia for her contributions to nursing.

The new ICN president has had a varied nursing career encompassing public health, acute care, and operating room nursing as well as administration. At present, she is matron of Sir Charles Gairdner Hospital in Perth, Western Australia.

Also elected to the ICN Board of Directors, 1977-1981 are: *First vice-president:* **Rebecca Bergman,** professor of Nursing Department, Tel Aviv University, Israel.
Second vice-president: **Verna Huffman Splane,** faculty of the School of Nursing, University of British Columbia, Canada.
Third vice-president: **Hildegard E. Peplau,** former director, Graduate Program, College of Nursing, Rutgers University, U.S.A.
Members-at-large: **Ang Mun Moi** nursing officer and head, Nursing Unit, Singapore General Hospital and Faculty of Dentistry, Singapore.
Ingrid Hamelin, nursing officer, Helsinki City Hospital and Social Services Planning Bureau, Finland.
Eunice Muringo Kiereini, chief nursing officer, Ministry of Health, Kenya.
Sheila M. Quinn, area nursing officer, Hampshire Area Health Authority (Teaching), United Kingdom.

Area Members
Africa: **Eloise C. Duncan,** administrator, Nursing Services, John F. Kennedy Medical Center, Liberia.
Eastern Mediterranean: **Hend Abdel-Al,** lecturer, Psychiatric Nursing, High Institute of Nursing, Cairo University, Egypt.
Europe: **Marie-Louise Badouaille,** National Association of Continuing Education of Public Hospital Personnel, France.
North America: **Eileen M. Jacob,** professor and dean, School of Nursing, The University of Texas at El Paso, U.S.A.
South and Central America: **Syringa Marshall-Burnett,** lecturer, Advanced Nursing Education, University of the West Indies, Jamaica.
Southeast Asia: **Annamma P. Cherian,** principal, College of Nursing, Post Graduate Institute, Chandigarh, India.
Western Pacific: **Fe M. Valdez,** chairman, Board of Nursing, Professional Regulation Commission, Phillipines.

Norah O'Leary, Nursing Consultant has been transferred from the Health Consultants Directorate to the Health Standards Directorate of the Health Programs Branch, Health and Welfare Canada.

O'Leary obtained her M.Sc.N. from the University of Toronto and is a clinical nurse specialist in cardiovascular nursing. She was an assistant professor in the Faculty of Nursing at Lakehead University before joining Health and Welfare in 1976. She is a member of the Board of Management and the Executive Committee of the Board of the Registered Nurses Association of Ontario and is past president of the Nurses' Section, Ontario Lung Association.



O'Leary's responsibilities with the Health Standards Directorate will involve the establishment of guidelines and standards for nursing practice. To do this, she will be working closely with the Canadian Nurses Association, the provincial associations and government agencies. She pointed out that many specialized nursing groups and provincial associations across the country have already set up their own standards of practice and that, as a result, there are a vast number of resource people to draw on in setting up national standards of nursing practice. In her work, she plans to travel to the provinces to meet with these various groups.

In describing her position, she stressed that "this is not the federal government imposing their standards on the nursing profession. It is up to nursing to define nursing practice. My job is to coordinate and facilitate the work of expert practitioners in setting up national standards."

O'Leary sees that the establishment of standards is an acute need in nursing. One of the priorities of CNA since 1975 has been to develop a definition of nursing practice and to establish national standards. "At present, there is no objective criteria to judge the quality of care that is being given. Standards are one way of measuring the quality of our care."



H. Rose Imai will leave her position as acting Principal Nursing Officer, Health and Welfare Canada to join the staff of the Canadian Nurses Association as director of professional services in early September. She will also assume the role of deputy director of CNA in the absence of Dr. Mussallem.

Imai received her diploma in nursing at the Moose Jaw Union Hospital in Saskatchewan and then went on to obtain her bachelor's degree in nursing at McGill University and her master's degree in public health at Johns Hopkins University. She has nursed in a variety of settings including work in Japan and Okinawa and public health nursing in Toronto. She has also taught at McGill's school of nursing.

Imai was previously on the staff of CNA from 1970-1972 as a research officer preparing submissions to government and drafting position papers.

Robert Gourdeau, M.D., F.R.C.P.(C) was recently elected president of the Canadian Medical Assocation for 1977-78. At present, he is a consultant in pediatrics and hematology at the Centre Hospitalier de l'université Laval in Ste. Foy, Quebec.

Calendar

October

Interim Council on Health Sciences Education of Canada (ICHSEC) First Annual Meeting. To be held at the Hotel Meridien, Montreal on Oct. 2-4. Theme: Accreditation and Health Sciences Education. Contact: *C.A. Casterton, Executive Secretary, Association of Canadian Medical Colleges, 151 Slater St., Ottawa, K1P 5H3.*

Workshop on Diagnosis of Venous Thrombosis: Theoretical and Practical Approaches, to be held at McMaster University Medical Centre, Hamilton, Ontario, on Wednesday, Oct. 26. Contact: *Dr. J. Hirsh, Professor, Department of Pathology, McMaster University Medical Centre, 1200 Main Street West, Room 3N18, Hamilton, Ontario, L8S 4J9.*

Annual Meeting and Workshop of the Association of Remotivation Therapists of Canada Inc. to be held at the Douglas Hospital in Montreal, Quebec on Oct. 3-5, 1977. Fee: $30. Contact: *Mr. P. Steibelt, Director of Remotivation Therapy, Douglas Hospital, 6875 LaSalle Blvd., Montreal, Quebec, H4H 1R3. (514) 761-6131.*

Therapeutic Touch as it Relates to Nursing Practice. A one-day symposium given by Dr. Dolores Krieger designed to expose nurses to new scientific findings on "touch." To be held Oct. 27 at the University of Calgary, Calgary, Alta. Fee: $18. Contact: *Mary Hammond, R.N., Administrative Officer, Division of Continuing Education, The University of Calgary, 2920 24th Avenue N.W., Calgary, Alberta, T2N 1N4.*

Association of Registered Nurses of Newfoundland 23rd Annual Meeting. To be held on Oct. 3-5, at the Hotel Gander, Gander, Nfld. Guest speaker: Lorine Besel. Contact: *ARNN, 67 Le Marchant Rd., St. John's, Nfld., A1C 2G9.*

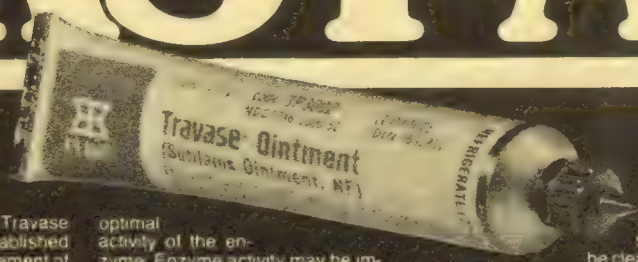
November

Order of Nurses of Quebec Annual Meeting to be held on Nov. 9-10, 1977 at the Queen Elizabeth Hotel, Montreal. Contact: Order of Nurses of Quebec, 4200 Dorchester Blvd. West, Montreal, Quebec.

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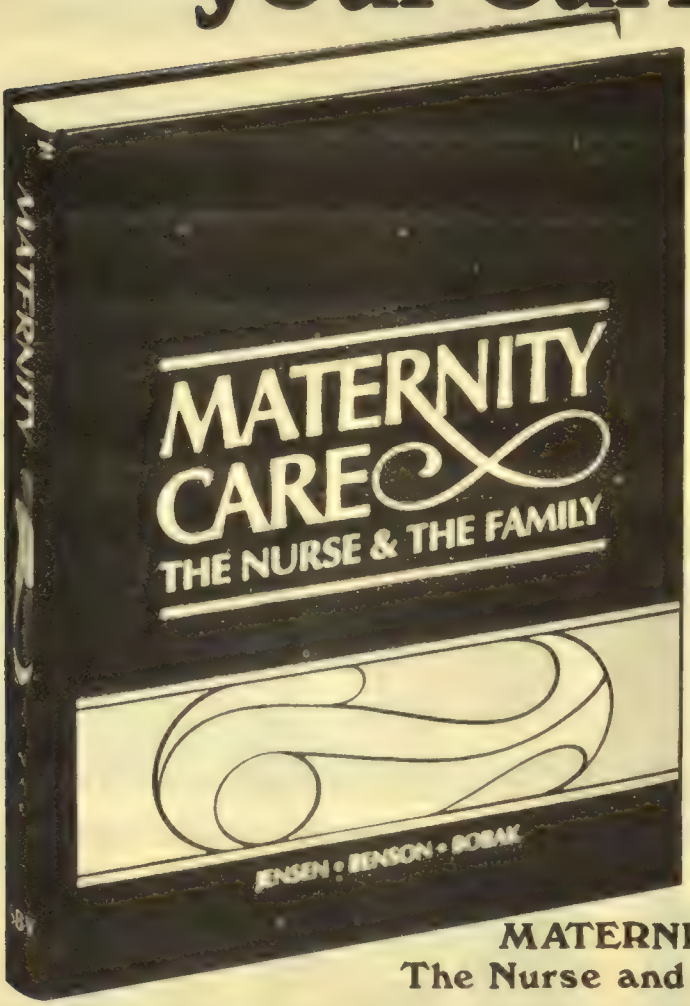
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By Margaret Duncan Jensen, R.N., M.S.; Ralph C. Benson, M.D.; Irene M. Bobak, R.N., M.S.; with 2 contributors. April, 1977. 764 pages plus FM I-XX, 8½" × 11", 684 illustrations. Price, $18.40.

Medical/Surgical

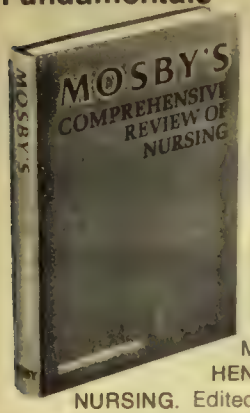


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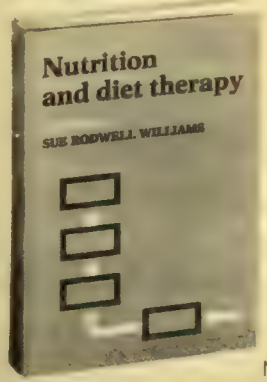
Fundamentals



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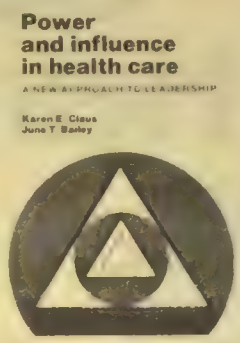
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Books

Cancer Care Nursing by Maureen Ivers Donovan and Sandra Girton Pierce, New York, Appleton-Century-Crofts, 1976.
Approximate price $9.75.
Reviewed by June M. Davidson, Head Nurse, Oncology Unit, Ottawa Civic Hospital, Ottawa, Ontario.

This book has been written by nurses and for nurses. Its authors, Donovan and Pierce, have provided a comprehensive approach to the cancer nursing problem. In the preface, they state, "one of the main goals of this work is to influence the philosophy of nurses who work with cancer patients."

There is a recognized need for nurses in the field of oncology. In order for patients to receive optimum care, we have to change our negative attitudes about cancer. Each person needs hope, something to look forward to, and this book attempts to help us fulfill that need. It is above all a practical book, guiding the nurse towards a systematic and positive approach to cancer nursing.

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A chapter concerning pain is a comprehensive review of many theories regarding pain and the implications of pain. The chapter offers practical ways of dealing with the patient who has pain or fears pain, along with methods of control.

Infection, an ever present problem and threat to cancer patients, is well handled by this text. The book goes into the causes of infection, and outlines ways of dealing with and controlling infections. Nutrition and elimination problems of cancer patients are also covered.

The last chapter of the book deals with the patient's body image, the devastating effect of cancer on the human body, and offers practical suggestions towards dealing with the patient's feelings about his body.

The book has a thorough bibliography at the end of each chapter. It is a concise and worthwhile handbook; students and graduates alike will benefit from reading it and applying its direction.

The EKG — Basic Techniques for Interpretation by Jerome Passman and Constance D. Drummond. 306 pages, New York, McGraw Hill, Inc. 1976.
Reviewed by Lorna Rankin, Instructor, General Hospital School of Nursing, St. John's, Newfoundland.

This book, designed for anyone interested in EKG interpretation, would be found useful by many nurses, particularly those working in critical care areas.

The authors, two American cardiologists, pioneered the concept of having the technicians report on, as well as actually produce, the EKG tracings, on the principle that the technicians would find their work more satisfying and reporting would become more efficient.

Readers with some prior knowledge of electrocardiography can skim through the first three chapters which outline the anatomy and physiology of the heart, describe the various waves, complexes and intervals of the EKG, and how to measure them. The remainder of the book describes the cardiac axis, specific abnormalities of rhythm and waveforms and the changes that can occur in a wide variety of clinical conditions.

The book, written as a programmed learning text, is valuable, both as a practical guide and as a reference when specific abnormalities are encountered. It deliberately gives no details of the theory behind heart diseases or the treatment (these may be found in other texts), but can be highly recommended for nurses wishing to enlarge their knowledge of electrocardiography.

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Requests for loans, maximum 3 at a *time*, should be made on a standard Interlibrary Loan form or by letter giving author, title and item number in this list.

If you wish to purchase a book, contact your local bookstore or the publisher.

Books and documents

1. Barber, Janet Miller. *Adult and child care; a client approach to nursing,* by... Lillian Gatlin Stokes and Diane McGovern Billings. 2ed. St. Louis, Mosby, 1977. 1036p.
2. *Behavioral approaches to children with developmental delays,* by Sally M. O'Neil, Barbara Newcomer McLaughlin and Mary Beth Knapp. St. Louis, Mosby, 1977. 210p.
3. Canadian Teachers Federation. *Bibliographies in education, no. 59. Evaluation of student teachers.* Ottawa, 1977. 76p.
4. Canadian Tuberculosis and Respiratory Disease Association. Standards Committee. *Reports.* Ottawa, 1972. 65p.
5. Carter, Joan Haselman. *Standards of nursing care; a guide for evaluation,* by... et al. 2ed. New York, Springer, 1976. 292p.
6. Fraiberg, Selma H. *The magic years; understanding and handling the problems of early childhood.* New York, Scribner's, c1959. 305p.
7. Gannik, Dorte. *The national health system in Denmark: a descriptive analysis,* by... Erik Holst and Marsden Wagner. Washington, U.S. Public Health Services, 1976, 86p. (U.S. DHEW Publication no. (NIH) 77-673)
8. Hughes, Harold Kenneth. *Dictionary of abbreviations in medicine and the health sciences.* Lexington, Mass., Lexington Books, 1977. 313p. **R**
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12. Marshall, T. David. *Patients' rights: what you should know before seeing a doctor.* Vancouver, International Self-Counsel Press, c1976. 70p.
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Index of Canadian Nursing Studies: 1976 Addendum

The 1976 Addendum to the *Index of Canadian Nursing Studies* is now available. This Addendum lists all research studies by Canadian nurses or about nursing in Canada on which information was retrieved in 1976. It is not limited to studies completed in that calendar year. This Addendum is available at $1.00 per copy from the Publication Order Department, Canadian Nurses Association, 50 The Driveway, Ottawa, K2P 1E2.

The 1976 Addendum is the second Addendum to the last cumulated index which was published in 1974. The cumulated index with the Addenda for *1975 and 1976 may be purchased for $7.00 per copy.*

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16. Wade, Jacqueline F. *Respiratory nursing care; physiology and techniques.* 2ed. St. Louis, Mosby, 1977. 231p.
17. Western Interstate Commission for Higher Education. *Communicating nursing research vol. 8: nursing research priorities: choice or chance.* Edited by Marjorie V. Batey. Boulder, Colorado, 1977. 379p.
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20. Airline Users Committee. *Care in the air; advice for handicapped passengers.* London, Civil Aviation Authority, 1977. 20p.
21. Canadian Council on Hospital Accreditation. *Report 1976.* Toronto, 1977. 5p. **R**
22. Canadian Medical Association. Council on Medical Services. Sub-Committee on Primary Medical Care. *Primary medical care: Resource document.* Calgary, 1973. 39p.
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24. Conseil canadien d'agrément des hôpitaux. *Rapport annuel 1976.* Toronto, 1977. 5p. **R**
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37. Bureau de Recherches sur les traitements. Commission des relations de travail dans la fonction publique. *Analyse des conventions collectives dans la fonction publique du Canada.* Ottawa, 1976. 1v. (various pagings)
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41. Dept. of the Solicitor General. *Report 1974-75.* Ottawa, Information Canada, 1976. 50p.
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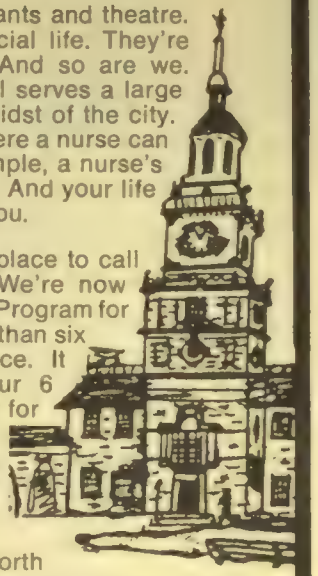
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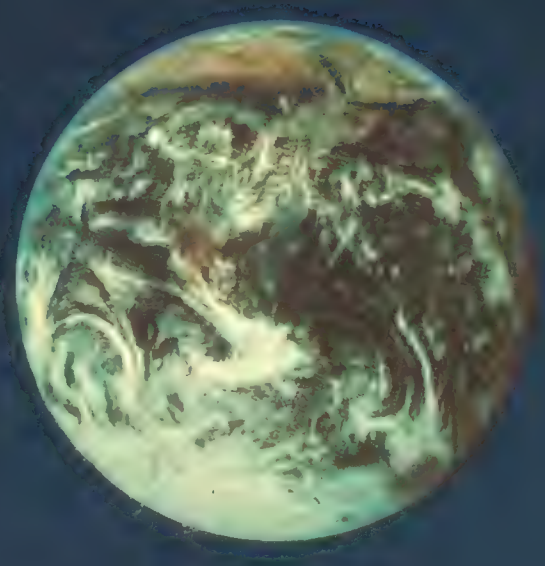


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the canadian nurse

October 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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Electronic wizardry. It's part and parcel of living in the seventies. We have learned to co-exist with intercoms and transistors, microwaves and even Instabank. But what about the life-supporting machines that we work with every day? Author Laura Worthington, whose article, "Things that go bump in the night," begins on page 18, says a whole new world awaits the nurse who takes it upon herself to develop a more informed and responsible attitude towards the medical devices that surround her. The electronic wizard cum nurse on our cover is CNJ assistant editor, Sandra LeFort. Photoart by Studio Impact of Ottawa.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Perspective



Photo courtesy Children's Hospital Eastern Ontario

The basic contribution of industrial democracy has been to reduce the disparity between the rights of the individual as a worker and his rights as a citizen. (Report of the Task Force on Industrial Relations, Ottawa, 1969, page 97).

In Canada, the collective bargaining process, like our legal system, is based on the adversary system. Differences between management and workers are resolved through conflict or the threat of conflict.

In the case of organized professional workers, the issues at stake are far more complex than the bare essentials of wage and fringe benefits. Conflict, in these instances, is more likely to center on issues related to the protection of the "professional role" and assurance of conditions and standards of "professional performance."

When these demands can be translated into monetary terms — such as provision for continuing education days, for example — they pose relatively little threat to the relationship. It is when "professional prerogatives" threaten to impinge on "management rights" that trouble arises. When, for example, teachers demand the right to have a voice in determining curriculum content, how many students will be in their classrooms and how they will discipline these pupils, their demands are seen as limiting the discretionary power of management and school boards react accordingly.

When nurses insist on their right to express an opinion on the number of patients they can care for safely, or who is qualified to perform a task such as dispensing medications, they encounter similarly strong employer resistance.

Many professionals consider that participation in policy decisions such as patient workload constitutes one of the hallmarks of professional status. Management, on the other hand, is apt to feel that the employer who recognizes the right of workers to help determine the rules that prevail in the workplace, is giving up a little of the prerogative that is traditionally his "to assign the work as he sees fit."

That is why nurses in Ontario are hailing announcement of the details of an arbitration award affecting nurses at Mount Sinai Hospital in Toronto as "a major breakthrough." At the heart of the matter is a "professional responsibility clause" in the agreement that provides for the establishment of an outside forum to make recommendations concerning conflicts over workload and patient care.

The forum, or "independent assessment committee" as it is described in the award will consist of three registered nurses — one chosen by the Ontario Nurses Association, one by the hospital and one from a panel of four independent registered nurses "well respected within the profession." When a nurse feels that she has been asked to perform more work than is consistent with proper patient care she is to complain in writing to the union-management committee.

Complaints that are not resolved to the satisfaction of both parties by this committee within a specified time will be forwarded to the panel. The expectation is that most complaints will be settled quickly without resort to the outside panel.

Officials of the Ontario Nurses Association will assess the effectiveness of the professional responsibility clause over the next two or three years.

In the meantime, we must agree with them in their description of the award as a significant step in the direction of "recognizing the right and responsibility of the nursing profession at large to be involved in assessing quality and quantity of nursing care within a health agency."

— M.A.H.

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Herein

The nursing process, is it all pie in the sky? Not according to author Lorraine Hagar. In her article starting on page 38, she explains the "common sense" element of the nursing process and demonstrates its application in the nursing care of Brian, one of her young patients.

World statistics on **infant and maternal mortality** rates indicate that hospitals may not necessarily be the best or safest places to have babies. Holland, where seven out of ten babies are born at home with midwives in attendance, has one of the world's lowest infant mortality rates. Rates in the U.S. and Canada are comparatively high.

Using these and other arguments, North American childbearing women and their partners are questioning the traditional hospital birth. They say they are seeking a childbirth experience that is both physiologically safe and psychologically satisfying — in short a family-centered experience.

Next month, authors Alison Rich and Elaine Carty of Vancouver share their observations about how four alternative childbirth centers (ABC's) in the United States are providing a **safe, family-centered environment.**

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

At home with exotic diseases

With the rising interest in Canada, with regard to "imported" and "exotic" diseases, some points may be useful to Canadian nurses who might encounter such new conditions.

Always ask a patient, "Where have you been?" Even a few minutes in a foreign airport is sufficient time for a malaria- or dengue-infected mosquito, to transmit disease to a traveller. Pinpointing the travel area can help to save life, in the case of the often fatal *P. falciparum,* for instance, where speed in diagnosis and treatment is vital.

In the case of possible viral infections, for personal safety, as well as that of others, adequate knowledge and practice of the "barrier" techniques are essential. Such techniques and practice may have to become post-basic courses for nurses likely to be involved in caring for such cases. *"Nursing Mirror,"* (G.B.), May 26, 1977, vol. 144, No. 21, pp. 13-18, has a most informative article on the nursing care of Marburg virus, with first priority on "barrier" techniques, rather than on the Trexler negative-pressure plastic isolator with air filtration, Tyvec suits for the health team staff, etc.

Nurses should be aware of their provincial "tropical disease" clinic centers, and nursing libraries should have available the standard textbooks for referral. An excellent handbook for nurses' personal libraries, is *"Control of Communicable Diseases in Man"* Abram S. Berenson, M.C., American Public Health Association.

In English-speaking Canada, the *"International Health Program,"* post-basic, in Parasitology and Infectious Diseases, will be available again at Seneca College of Applied Arts and Technology, Willowdale, Ontario, starting in September. National Health and Welfare has *"Canada Diseases Weekly Report,"* and the U.S. Department of Health, Education, and Welfare Center for Disease Control *"Morbidity and Mortality Weekly Report,"* with both carrying interesting accounts of diseases abroad as well as at home. In the global world of today, not just public health nurses, but most nurses may ultimately be involved with some of the exotic diseases during their professional careers.

P.S. Interested nurses are welcome as members of the Division of Tropical Medicine and International Health, soon to be known as the "Society" of the Canadian Public Health Association.

— G.C. Pope, R.N., P.H.N., Toronto, Ont.

A role for PHNs

In relation to your interview with Shirley Post of the Canadian Institute of Child Health, July 1977, I am deeply concerned that she seems unaware of the fact that public health nurses have been and are presently directing the major portion of their professional time to the health needs of children. At no point in the interview does she indicate that she interviewed or consulted with these valuable community workers.

Was this an oversight in reporting or an oversight in research?

— Reta McBean, Public Health Nurse, Pembroke, Ont.

The author replies:

Thank you for giving me an opportunity to reply to Ms. McBean's letter. Please assure her that in preparing the feasibility study for the Canadian Institute of Child Health — a number of public health nurses, some medical officers of health and the Canadian Public Health Association were consulted.

I am aware of the important role that public health nurses play in child care. However I also believe that in many communities they are underutilized. Public health nurses have the skills necessary to play an even greater role in preventive health care for children if given the opportunity to do so.

The Institute would like to hear from public health nurses regarding their role. We'd like to know if they feel they are being fully utilized and if not what factors might be preventing them from playing an expanded role in child health.

— Shirley Post, Canadian Institute of Child Health, Ottawa, Ontario.

More funds for C. Ed.

The dilemma of mandatory continuing education vs. voluntary continuing education is one which concerns every nurse and nurse administrator. I am against regimentation and legally forcing people to do what they do not, really want to do. I must therefore, present as being against mandatory C.E. for renewal of registration as is practiced in some states. I must, though, express my firm belief that unless nurses remain abreast of the continuing changes in the health care spectrum they may not be giving the client the care that he deserves.

I would like to commend Nora J Briant for her article "What every reasonable prudent nurse should know" (May, 1977); and add that our provincial nurses' associations must indicate their support for continuing education by budgeting larger sums of money for this area and generating more activity than is now evidenced in some provinces. Our associations must also bring pressure to bear upon our provincial governments (through our nursing representatives) to recognize the need for continuing education for all health care workers, and insist on government increasing budget allocations for staff development. It will then be incumbent on directors of nursing to make sure that nurses get their fair share of the budget and participate in programs internally and externally.

— G. Hollingsworth, director of nursing, Provincial Hospital, Saint John, N.B.

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New family association

This letter is to introduce your readers to the Canadian Cleft Lip and Palate Family Association. Our association, now one and a half years old, is the first of its kind in Canada, although in the U.S. there are 50 groups of this nature. Our sponsor is the Hospital for Sick Children in Toronto.

The initial aim of the association is to set up a newborn program through which parents of infants with cleft palates will receive assistance and information. Another aim is to develop a resource center with information about the cleft lip and palate condition. It will be the members themselves, as they assist and learn from one another, who will determine the ultimate form the association will take.

We are fortunate in having competent professional advisors for the association who will be available for general educational purposes.

For further information: *Elise Bossin (Mrs.), Coordinator, Canadian Cleft Lip and Palate Family Association, 4981 Bathurst Street, Apt. 215, Willowdale, Ont. M2R IY5.*

Lost and found

The 1941 graduating class of Newark Beth Israel hospital in the United States included at least one Canadian nurse. Now that I am in Canada, I would appreciate renewing contact with some of these classmates who are probably readers of this journal.

— Pearl (Koweek) Newton, associate professor, Dalhousie University school of nursing, Halifax, N.S.

Moving, being married?

Be sure to notify us in advance.

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Mail to: ***The Canadian Nurse,*** 50 The Driveway. Ottawa K2P 1E2



Calendar

Correction

Order of Nurses of Quebec Annual Meeting will be held on Nov. 9-10, 1977 at the Quebec Municipal Convention Centre, Quebec City not in Montreal as previously printed. Contact: *Order of Nurses of Quebec, 4200 Dorchester Blvd. West, Montreal, Quebec.*

November

Canadian Intravenous Nurses Association 2nd Annual Convention to be held in Toronto, Ontario at Inn on the Park Hotel — November 23-24th, 1977. Contact: *C.I.N.A. - Box 481, Station Z, Toronto, Ontario, M5N 2Z6.*

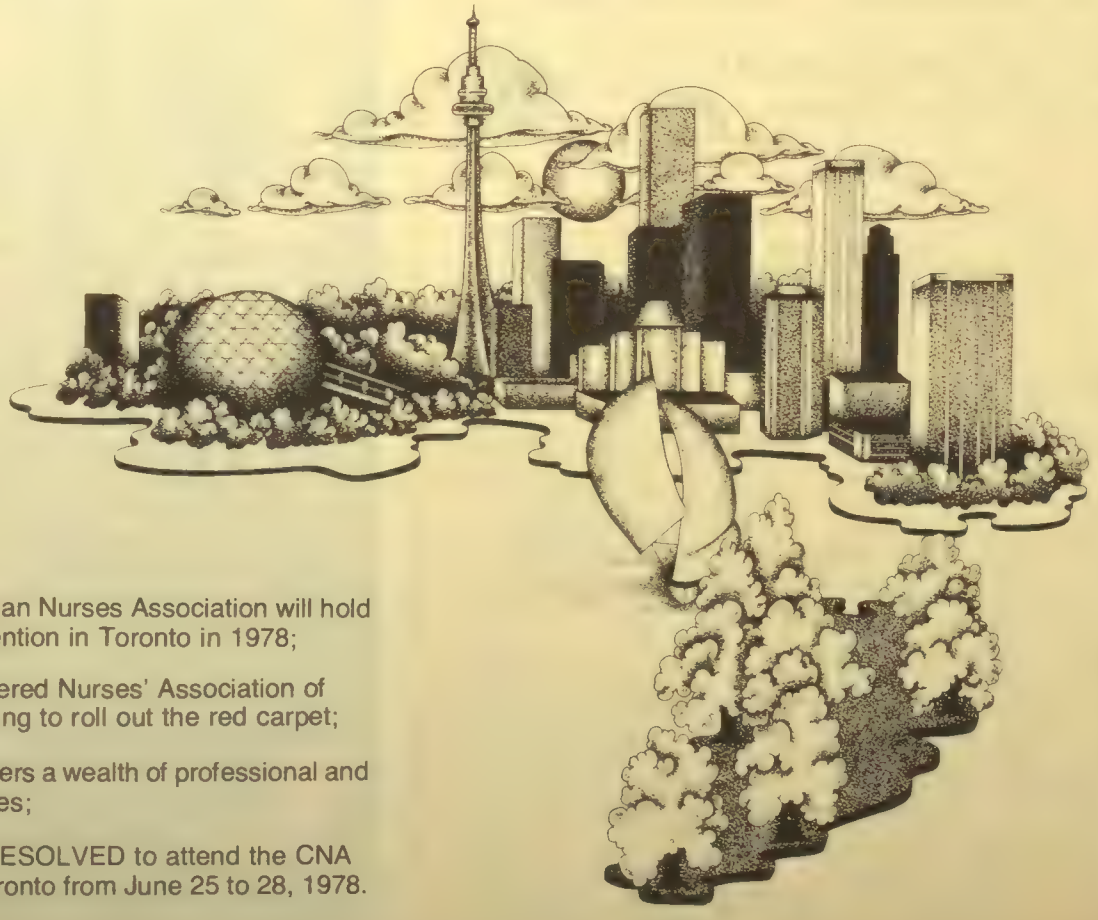
Parent to Infant Attachment: Strengthening the Family in the Perinatal Period. A four-day conference to be held on Nov. 6-9, 1977 at the Bond Court Hotel in Cleveland, Ohio. Sponsored by the Rainbow Babies' and Children's Hospital. Contact: *Marilyn Griffith, Assistant Director, Public Relations Dept., Rainbow Babies' and Children's Hospital, 2101 Adelbert Rd., Cleveland, Ohio, 44106.*

Conducting Performance Reviews — a two-day program for health care professionals who are expected to review the performance of others. Techniques to use in conducting the actual interviews will be presented with concrete examples. To be held in Toronto on Nov. 14-15, 1977. Tuition: $120. (Tax deductible). Contact: *R.M. Brown Consultants, 1115-1701 Kilborn Ave., Ottawa, Ontario, K1H 6M8.*

One-day seminars for helping professionals to be held at Ashtonbee Conference Centre, Scarborough, Ontario. Speaker: Jackie Barber, R.N., B.Sc.N., MEd. *Power and conflict in the professional work setting* on Oct. 20; *Group dynamics and leadership* on Oct. 27; *Supervision and discipline* on Nov. 3; *The helping relationship* on Nov. 10; *Evaluating staff* on Nov. 17; *Working with families* on Nov. 24. Contact: *Roy DelBianco, Co-ordinator, Conferences and Seminars, Centennial College, Continuing Education Division, Ashtonbee Conference Centre, 651 Warden Ave., Scarborough, Ont., MIL 3Z6.*

Ontario Nurses Association Annual Meeting to be held Nov. 16-18, 1977 at the Constellation Hotel in Toronto. Contact: *Rita Kohan, Administrative Assistant, Ontario Nurses Association, Suite 1401, 415 Yonge Street, Toronto, Ontario, M5B 2E7.*

Conjoint Meeting on Infectious Diseases to be held at the Chateau Laurier Hotel, Ottawa, Ontario on Nov. 23-25. Sponsored by the Tropical Medicine and International Health Laboratory Divisions of the Canadian Public Health Association. Contact: *Dr. P.F. Stuart, Dept of Microbiology, Toronto General Hospital, Room 215, 100 College Street, Toronto, M5G IL5.*



WHEREAS the Canadian Nurses Association will hold its biennial convention in Toronto in 1978;

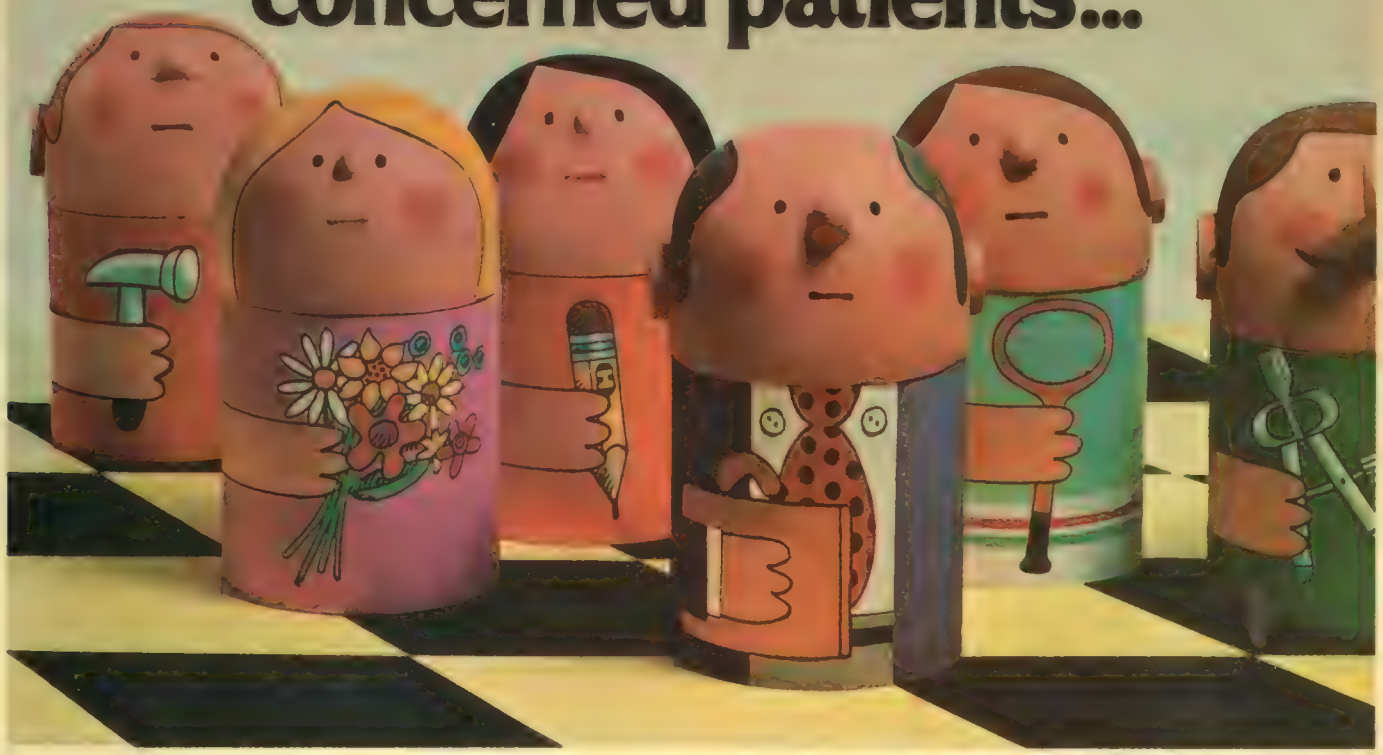
WHEREAS the Registered Nurses' Association of Ontario is preparing to roll out the red carpet;

WHEREAS Toronto offers a wealth of professional and social opportunities;

THEREFORE BE IT RESOLVED to attend the CNA Convention in Toronto from June 25 to 28, 1978.

Artwork courtesy of Versatel Corporate Services Limited Don Mills Ontario

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News

World Federation for Mental Health draws 2100 concerned professionals

The stigma attached to mental illness should be a first priority for those working with the mentally ill, for it is negative public attitudes that are holding back progress in the field, says **Rosalynn Carter,** wife of United States' President Jimmy Carter.

"This self-feeding cycle of fear, discrimination and lack of understanding about mental illness is more than a vague uneasiness we detect from time to time. It is a very real and troubling fact," she told delegates to the 1977 Congress of the World Federation for Mental Health in Vancouver in mid-August.

Carter was speaking during a special session for the more than 2,100 registrants, inoluding 350 nurses, from 44 nations. Her message summed up much of the five days of sessions, lectures, debate and workshops that were to determine as the Congress theme put it, "Today's Priorities in Mental Health."

"The data our Commission has gathered show that the public continues to be repelled by the notion of mental illness — although it is becoming less socially acceptable to say so," Carter said. Even when patients manage to overcome their fears and shame and finally seek professional help, there are still attitudes that need to be scrutinized; patients often run into as much fear and prejudice from professional workers as from the general public.

"We need to try to create a national commitment, a national attitude, a national climate for the proper care and treatment of the mentally ill," she said.

Another highlight of the week-long convention that drew together psychiatrists, social workers, psychologists, teachers, mental health volunteers and nurses was a debate between **Ivan Illich**, author of *"Limits to Medicine: Medical Nemesis,* and **Morris Carstairs,** vice-chancellor of the University of York, England, on the role of professionals in today's society.

Illich repeated his thesis that professionals have become too strong through their organizations and now completely dominate individuals who have had to surrender all responsibility for their own health.

He accused the professions of being "disabling" rather than "enabling," or helping, because they create dependence. The professions jealously guard their body of knowledge, shrouding it in almost religious trappings so individuals cannot understand the facts on which care is based.

Carstairs replied that many of Illich's ideas were so "safely Utopian there is little possibility of their being put into effect." He denied that the medical establishment is trying to take over, but agreed that individuals ought to assume more responsibility for their care when it is within their power to do so.



Chairman Dr. Milton Miller (left) and president Dr. Tsung-yi Lin of the WFMH, are pictured during recent Congress. Both are from Vancouver. (Photos by Kent)

Also drawing a large crowd at a main session was anthropologist/author, **Margaret Mead,** who questioned Western attitudes towards leisure and retirement. Westerners seem to believe that leisure exists merely to refresh people so they can work harder the next day or the next week, she said disdainfully. She also scorned the idea of mandatory retirement, saying retirement can kill.

"All the evidence we have at present is that stopping abruptly what we're doing and, equally, imposing non-participation on children and adolescents and keeping people out of the working world, is one of the most disastrous things we can do to them."



Fitness Minister Iona Campagnolo addresses participants in "Health by the People" meeting.

Opening speaker at the Congress was **Iona Campagnolo,** Canada's Secretary of State responsible for fitness and amateur sport. She spoke of the value of physical exercise to combat stress and anxiety, referring to activity as "nature's tranquilizer," and adding that Hans Selye, the father of the theories related to stress, advises physical activity as one of the most effective ways of channeling and balancing stress.

Campagnolo noted that a sub-theme of the Congress was "Health by the People," with its attendant emphasis on prevention and individual responsibility for one's own well-being. She urged Canadians to be their own fitness planners and "achieve an extra measure of pride and satisfaction in addition to those physical and mental benefits."

Many of the papers presented at the workshop sessions were given by nurses, including some of the research papers. **Joan Anderson** of the faculty of nursing at the University of British Columbia reported on her recent study that showed nursing students are more negative than professionals in their predictions about the futures of psychiatric patients. She said students depend on and are influenced by diagnostic labels. However, if the diagnosis is concealed, the students are more positive and tend to use their observations more wisely. If the diagnostic label is present, the students rely less on observation. However, they are more positive toward the prognosis than if no diagnosis is given for the patient. Anderson sees the study as having implications for education of nursing students, saying, "There needs to be emphasis on observation of behavior and on arriving at conclusions from direct observations rather than from the diagnostic label alone."

—Glennis Zilm

Special isolation unit

A two-day meeting of federal and provincial Health Ministers in Ottawa was told of a plan for a three-level approach to handling persons who enter Canada with dangerous **communicable diseases.** The national plan would consist of three lines of defence:

a) stretcher-type plastic isolators to be maintained in selected international airports in Canada

b) bed-type isolators to be stationed in strategic hospitals under provincial auspices at major centers in Canada

c) a central facility to provide a fully secure environment.

Health Minister Marc Lalonde said that the special isolation unit, costing approximately $3 million will be built in Ottawa. The unit, comprising six beds would be as impenetrable "as the Bank of Canada and would ensure the disease would not spread."

The three lines of defence are to be linked by highly skilled medical evacuation Canadian armed forces personnel using a transit isolator and armed forces aircraft.

VON appoints financial adviser

The Victorian Order of Nurses for Canada is well on its way to implementing the nine recommendations made by Edward A. Pickering in his study of the future role of the VON. In his 1976 report "A Case for the VON in Home Care," Pickering's suggestions included, among others, that organizational changes were needed, such as adding a business executive to the national office staff and making a professional study of budgeting and cost accounting.



In light of these recommendations, the VON are making changes at the national, provincial and local levels, says Lorette Sutton, assistant director at VON National Office. "Since more and more of our funding now comes from government agencies, the VON is working towards improving its methods of budgeting, to correspond with government expectations." A professional study on budgeting and cost accounting has already been completed in the province of Ontario, she said.

In August, VON president R.G. Smethurst of Winnipeg announced the appointment of Bruce Daubney of Ottawa as an advisor in the field of financial administration and liaison with governments concerning financial arrangements for services provided by the VON.

Daubney is a past president of Computing Devices Company and also has had an extensive career with the Ford Motor Company of Canada.

Health happenings in the news

Dr. Blair Fearon of The Sick Children's Hospital in Toronto has removed the tonsils of four patients using a burst of light from a **laser** rather than scissors and knife. The procedure which destroys tissue by burning and vaporization takes about twice as long as conventional surgery — one reason why the laser tonsillectomy will be limited to cases where blood loss is a problem. The laser's accuracy makes it possible to treat other conditions such as narrowing of the windpipe.

Dr. Fearon said that the four tonsillectomy patients suffered much less and nurses were amazed at the speed of recovery.

The major findings of the **Nutrition Canada Dental Report** of Health and Welfare Canada show that:

- Dental caries is the leading cause of tooth loss in persons under 35 years of age. Ninety-six per cent of adults over 19 years of age had dental caries.
- The percentage of children aged 12-14 years with good teeth, i.e. zero DMF teeth (DMF is the number of decayed. missing and filled permanent teeth) appeared to be unrelated to income.
- Periodontal disease (a disease of the tissues which support the teeth firmly in the jaws) is the main cause of tooth loss in persons over 30 years of age. About 15 per cent of the adult population had obvious "pockets" of periodontal disease, a condition which was generally worse in men than women.
- Approximately 40 percent of adults aged 19 years and over had no teeth in one or both dental arches.
- A consistent beneficial effect of fluoridation in reducing the prevalence of dental caries was observed in children under 11 years of age.
- Thirty-nine per cent of children aged 12-14 were observed to have a malocclusion (a deviation from the normal, accepted manner in which the teeth of the upper jaw fit with those of the lower jaw). Thirteen per cent showed a serious need for treatment and one per cent an urgent need.

Respiratory nurses seek CNA affiliation

The Canadian Nurses Association could have its second affiliate member within a matter of months. The Canadian Nurses' Respiratory Society has announced that it will seek affiliation with the national organization that now represents 117,206 nurses in this country.

Last Spring, CNA directors approved an application from the Canadian Association of Neurological and Neurosurgical Nurses for affiliate membership in CNA.

Announcement of the CNRS decision was made following the annual meeting of the Canadian Lung Association (formerly the Canadian Tuberculosis and Respiratory Disease Association) in Moncton, N.B.

At the same meeting, the nurses' section of the association announced that it was changing its name from the Nurses' Section of the Canadian Tuberculosis and Respiratory Disease Association to the Canadian Nurses' Respiratory Society. A committee has been formed to select a suitable French equivalent.

U. of Victoria focuses on elderly

The newly established school of nursing at the University of Victoria in Victoria, B.C. is pioneering a health philosophy to ease the problems of old age.

In an interview with the *Canadian Press*, the director of the school, Isabel McRae stated that by the year 2000, one-quarter of the population will be older than 55 and the old nursing philosophy which emphasized care of the acutely sick will no longer be adequate.

"Our program is based on the idea that nurses are not junior doctors, but personnel trained: to help people maintain good health; to help patients tolerate the experience of ill health; and to help them live as satisfying lives as possible within the constraints of their dysfunction," she said.

McRae said that one reason that the university nursing school is able to focus on gerontology is that it is a post-graduate institution and not tied down to preparing nurses to write registration exams. Opened in 1976, it offers a two-year program leading to a bachelor of science degree in nursing.

AARN allocates $36,000 to continuing education

The Alberta Association of Registered Nurses has announced the award of two educational scholarships as part of the association's $36,000 annual allocation for continuing education. The Abe Miller Memorial and the Helen M. Sabin Scholarships are each awarded annually in the amount of $2.000 to assist members to continue graduate study of not less than one academic year.

This year, the Abe Miller Memorial Scholarship was won by Rhea Arcand, section head of the Post R.N. Nursing Program at Grant MacEwan Community College. Arcand has enrolled in the Master's in Nursing Program at the University of Alberta.

Karen Mills, assistant director of nursing, Edmonton Local Board of Health, was the winner of the Helen M. Sabin Scholarship. She will enter the Master's in Health Services Administration Program at the University of Alberta.

The A.A.R.N. also has an Educational Loan Fund available to assist members enrolled in graduate programs. This year 21 members of the A.A.R.N. have been allocated loans totalling $20,000 to assist them in pursuing baccalaureate and master's programs.

To complete the budgetary allocation in support of continuing education, the A.A.R.N. contributes annually in excess of $12,000 to the Canadian Nurses Foundation which exists to assist nurses in educational endeavors by providing scholarships bursaries and fellowships.

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News

CNA supports special interest groups

In March 1977, CNA directors adopted preliminary guidelines for the support of "emerging" special interest groups in nursing. The board of directors was acting in response to a resolution passed at the 1976 biennial convention, that called for the national association to actively encourage the establishment and development of additional special interest groups in nursing and to be prepared to offer financial assistance to such groups for organizational purposes and up to two years of operation.

In the past, CNA has provided support in various ways to emerging nursing groups of a national nature. Now, however, they have established specific guidelines that will provide special interest groups with moral and financial assistance. These preliminary guidelines are:

1. Advice from CNA will still be available, as CNA resources permit, but no financial assistance will be given to "established" organizations.
2. "Emerging" nursing special interest groups must meet the following criteria:
a) their organizers and potential members must be members of CNA
b) there must be a tentative statement of the proposed purpose and objectives of the interest group and these must be compatible with CNA purposes and objectives before funding assistance is considered
c) there should be at least one contact person designated in each province/territory before any funding assistance is considered
d) normally, not more than $500. will be given to any one group in their first year of operation; and normally any further financial assistance would be limited to a $500 allotment in their second year of operation
e) any financial assistance beyond the first $500 would be contingent upon the groups' having been incorporated.
3. Any group receiving financial assistance must provide a yearly report to CNA.

Nurses involved in forming national special interest groups are invited to apply for assistance by contacting: *Executive Director, The Canadian Nurses Association, 50 The Driveway, Ottawa, Canada, K2P 1E2.*

Bottle holders banned by federal officials

A federal ban on mechanical devices for propping infant feeding bottles went into effect late this Summer. Consumer and Corporate Affairs Minister Tony Abbott, who issued the warning, explained:
"While no deaths have been reported from the use of these devices, we are issuing the ban as a purely preventive measure based on suggestions of possible dangers to Canadian infants by representatives of the medical and nursing professions."

Directors of the Canadian Nurses Association, in response to a complaint from a member of the Manitoba Association of Registered Nurses, passed a motion in April 1975 recommending that the threat posed by these devices be brought to the attention of the appropriate authorities. The correspondence that followed involved the Consumers Association of Canada, manufacturers, retailers and federal officials.

In their letters, CNA directors pointed out that "If a child is being 'prop-fed' without supervision, regurgitated food may be drawn into the lungs and pneumonia could result. In an extreme situation, the infant's breathing could be cut off, resulting in death."

Did you know ...
Dr. Bruce Bistrian of Boston told the Canadian Medical Association annual meeting in Quebec that one-third to one-half of the patients in acute care hospitals will be malnourished. He stated that acutely ill people need double the usual amount of protein and 25% more calories than usual. He suggested that patients should have a "beefed up" version of the instant breakfast kind of food to sip at all day.

Did you know ...
Pediatric dentists say that children up to the age of 4 or 5 years do not have the necessary hand skills to clean their teeth thoroughly. Dentists suggested that an adult help the child brush his teeth at least once a day. Dentists were meeting at a conference on dental health in Toronto in April.

Hemophiliacs studied

A comprehensive study of the Canadian hemophiliac is currently being directed by Dr. Martin Inwood, a clinical hematologist and chairman of the Medical and Scientific Advisory Committee for the Canadian Hemophilia Society. With $90,000 in grants from federal, provincial and private sources, Dr. Inwood, assistant professor at the University of Western Ontario, began working on a census of the estimated 2,400 hemophiliacs in Canada in the early summer.

The survey of hemophiliacs is only one of several projects of the Advisory Committee of the Canadian Hemophilia Society. Plans are now underway for a central data bank. Anonymous data will be compiled at a central registry to provide up-to-date social, economic and medical information on hemophilia to be used by researchers.

Plans are also being made for the establishment of comprehensive hemophilia assessment centers at all Canadian medical schools. Dr. Inwood describes the proposed facilities as "centers of excellence" which would provide complete information about the rare blood condition and would offer assessment and treatment on a comprehensive basis.

Each of the centers across Canada would offer a multidisciplinary approach to assessment and treatment and would employ the services of a nurse, physiotherapist, physician, surgeon, social worker and psychiatrist. Once a patient's problems have been identified, he could then be treated by the appropriate health care professional.

Dr. Inwood said the development of new treatments, wider use of genetic counseling and creation of the "centers of excellence" will shift the emphasis to a more preventive approach. He also stated that a comprehensive social survey of hemophiliacs will be undertaken by his committee in the future so that "we can come up with a definite profile of what the Canadian hemophiliac is like."



News

CNA rep attends world food symposium

A recent symposium on Canada and World Food was told that there are tragic effects on infant mortality because of the move away from breast feeding in developing countries.

N.S. Scrimshaw of the Department of Nutrition and Food Science, Massachusetts Institute of Technology, was speaking to 170 agrologists, economists and others interested in the problem of world food at a three-day meeting in Ottawa. The Canadian Nurses Association was represented at the meeting by research officer Marion Kerr. Symposium participants presented papers on population, health, food production and processing, research, engineering, economics, the political and the social sciences.

Scrimshaw also stated that an often neglected aspect of the world hunger problem is the large post-harvest losses of food to rodents, insects, molds, simple spoilage and inefficient processing procedures.

"Yet most food-deficit countries could be self-sufficient or even food exporters if proper storage of grains were assured, if processing were more efficient and if spoilage of fruits and vegetables and fish were reduced," he said.

Another speaker, Helen Abell, consultant in socioeconomic development, said in her paper "The Forgotten Familiars and World Health" that the grass roots expressed needs of people in the Carribean, Africa and Indo-China are, in order of importance: drinkable water; basic tools; cooking fuel; midwives from their own district; and eradication of communicable diseases.

Other speakers at the conference pointed out that:

- Canada has very high food production costs and that there is a serious deterioration in Canada's agriculture-food industry;
- Canada should encourage third world countries to give agricultural development a high priority in their own domestic spending;
- there are no local agricultural training programs and no training abroad programs for women in third world countries.

Central registry for community nursing

A central registry for those applying for community health nursing positions in Alberta has recently been established by the Nursing Branch of the Division of Local Health, Alberta. Individual nurses enquiring about positions will be asked to complete an application form that includes geographical preference and availability status. Local health authorities with vacant positions will be sent completed applications and will remain responsible for screening, interviewing and selecting nurses.

Enquiries may be made to:
Registry for Community Health, Nursing Applicants,
Office of the Senior Nurse Consultant, Local Health Services,
4th Floor Administration Building,
109 St. and 98 Ave.,
Edmonton, Alberta, T5K 0C8.

Health happenings

A **Health Day,** with free checkups and demonstrations, attracted a sellout crowd of 200 senior citizens in downtown Toronto last month. The all-day clinic marked the conclusion of an "Aging Successfully" program conducted by St. Christopher House Older Adult Centre for residents of the community, including many Portuguese and Chinese-speaking people.

Program director Marcelle Abou Assaly said that planners emphasized the need for preventive care. She pointed out that many residents of the area are immigrants who have never become Canadian citizens and may not be eligible for financial assistance available to others. "Proper dental care and care of the feet," she said, "are the great needs of the elderly."

Twenty-four of those who attended the clinic had a podiatrist do their feet. Twenty-five of 29 who had dental checkups were found to have dental problems. Fifteen persons with defective vision were found among the 67 who came for eye tests; six of the 77 who had their lungs checked had lung trouble; 20 of 55 checked for arthritis were found to be affected by it; 17 of the 54 checked for diabetes were found to have the disease.

A Yale psychologist warns that once a person becomes overweight he is likely to become "highly, sometimes uncontrollably responsive to external **food-relevant stimuli.**"

Dr. Judith Rodin told members of the American Psychological Association attending their annual meeting recently that overweight people have an increased tendency to secrete insulin when they are stimulated by the sights and smells of food. Insulin, a hormone produced in the pancreas, leads to increased hunger and eating and promotes the storage of fat in the body. Obesity, she said, makes one less active and more unhappy because society discriminates against the overweight, and more likely to overeat in response to situations that produce anxiousness or arousal.

Moreover, said Dr. Rodin, the overweight person tends to try diet after diet, but once his self-discipline is momentarily weakened, the diet collapses in an overeating spree. She cast doubt on the theory that fat people are genetically destined to be fat, and said the research shows that overweight is primarily a result of lifestyle, helped along by what she called a national preoccupation with eating.

Dr. Rodin said the fight against obesity has become a $10-billion-a-year industry in the United States, "and yet the record of success in losing and keeping off weight is abysmally poor."

In the search for the **secrets of long life,** the Soviet Institute of Gerontology found that "work is an invaluable remedy against premature old age." A *Pravda* article which cited the effects of "pension illness" — the quick deterioration suffered by old people when they retire — stated that "Old age is not a time to be sedentary, but to be active." Soviet gerontologists also recommended getting married, having children, living in high places, eating moderately, drinking well water and talking a lot."

The Soviet Union claims to have 19,304 centenarians as of the 1970 census or 8 per 100,000 population compared to 1.5 per 100,000 in the United States.

The U.S. Bureau of the Census has identified some of the **changing patterns of marriage and family living** in our neighbor to the South, among them:

- The number of unmarried persons living with someone of the opposite sex doubled between 1970 and 1976.
- In the same period, the proportion of the population aged 25 to 29 who had never married increased substantially from 19.1 percent to 24.9 percent among men and from 10.5 percent to 14.8 percent among women.
- The divorce rate more than doubled between 1963 and 1975, from 2.3 percent per 1,999 population to 4.8.
- Of every 1,000 married persons in 1976, 75 had been previously married and divorced; in 1960 the ratio was 35 in 1,000.

Did you know ...

The originator of "Anstie's Alcohol Limit" was a physician-scientist-reformer named Francis E. Anstie who died more than 100 years ago in London, England. His dictum concerning the daily amount of alcohol that an individual can consume without risk of deterioration of health is still cited in Dorland's 25th Medical Dictionary as a rule used in connection with life insurance examinations: "the maximum amount of absolute alcohol taken daily without injury is 1 1/2 ounces, equivalent to about 3 ounces of hard liquor, a pint of light wine, or 24 ounces of bottled beer or ale.

Although Anstie's name is best remembered for his pronouncement on moderation, he was recognized during his lifetime as a tireless leader in the public health field who was responsible for many progressive measures connected with medical and nursing care in workhouse infirmaries and urban renewal.

When he died of septicemia at the age of 41, Florence Nightingale predicted: "Many will fall victims to the want of (pursuing) the public health measures of which he was such a devoted supporter."

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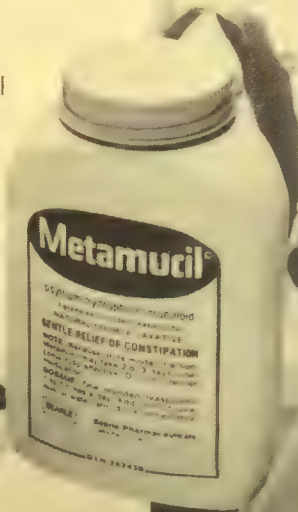
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Names and Faces

CNJ talks to

Suzanne M. Gouthreau

"Nurses must decipher which problems concern nursing and which do not; then they must learn to say "no." So says Suzanne M. Gouthreau of R.M. Brown Consultants, Ottawa. Along with her associate Ron Brown, Sue develops and presents a series of seminars to health care personnel in management positions covering such topics as management functions, time management, leadership style, motivation, and inter-personal relationships. The lively conferences are presented all across Canada at various times during the year in both English and French.



Sue completed her basic nursing education at the University of Ottawa School of Nursing, Ottawa General Hospital. She then went on to obtain her B.Sc.N.Ed. at the University of Ottawa in 1967. She has also engaged in graduate work in the Department of Business Administration at the University of Minnesota. During her experience as a head nurse in pediatrics and as an inservice education coordinator in a 600-bed acute care hospital, she saw the need for management courses for nurses.

"The role of the nursing manager has changed tremendously in the last ten years. Today they are given much greater responsibilities and they require more knowledge in such areas as finances, systems engineering, staffing, personnel selection and performance review. Traditionally, most professionals selected to fill management positions are the best practitioners in their field but may not necessarily be adequately prepared to deal with the growing complexities of health care organizations. The nursing manager of the present must have a strong and a positive self-image. She must be aggressive when necessary (yes, it is permissible) even if this role runs counter to earlier cultural and professional training. She must be a risk-taker and must know how to deal with conflict tactfully and from a position of strength. Being aware of the power bases within the organization and knowing the "jargon" of the business world can be a great asset to her in competing with others for the limited resources available."

Sue explained that almost all managers who attend the seminars are already practising their own set of management strategies. The seminars strive to provide the language of management, to reinforce present management practices and to provide alternative strategies that may be used in handling various management situations. She stressed that there is no such thing as the "cookbook" approach to management: there are no easy answers. Decisions must be made and there is never 100% gain. There are always some negative consequences. The critical factor in solving problems is in the climate of the organization — if relationships are open and if people talk to each other, they are half-way there.

Margery Furnell, (R.N., University of Alberta Hospital; B.Sc.N., University of Alberta; M.S.N., University of British Columbia) has joined Alberta Social Services and Community Health, Division of Local Health Services as a provincial nurse consultant. She will be located in Calgary as the first nursing consultant to be decentralized from the provincial office in Edmonton. Furnell also holds a joint appointment with the University of Calgary as an assistant professor.

Furnell most recently was an assistant professor at the University of British Columbia. She has had experience in teaching and community health in Alberta as well as working with the V.O.N. and in Home Care in Ontario.



Marilyn L. Carmack has been appointed assistant executive director of the Registered Nurses Association of British Columbia effective January 1, 1978. She will serve in this position until the following September when she becomes executive director.

Before joining the RNABC staff as employment referral director in 1974, Carmack was director of nursing at Riverview Hospital, Coquitlam. Her background includes inservice nursing education and psychiatric, surgical and general duty nursing. She is a graduate of the Calgary General Hospital School of Nursing, holds certificates in psychiatric and public health nursing, and earned a B.Sc. degree in nursing from the University of Washington at Seattle.

Carmack will succeed **Nan Kennedy** of Vancouver who retires next fall after eight years as RNABC executive director.

Michael Samuel Phillips has been appointed deputy director-administration of the newly formed Metropolitan Toronto Forensic Service, a pilot project of the government of Ontario. The service was established to provide psychiatric assessment services for those appearing in court who may be identified as having serious psychiatric and emotional problems.

Phillips received his nursing diploma at the University of the West Indies, Port of Spain General Hospital, a B.Sc.N. at the University of Toronto, and a diploma in hospital and health care administration from the University of Saskatchewan. Previously, Phillips was administrative nursing supervisor at the Clarke Institute of Psychiatry in Toronto.

New Appointments

The School of Nursing of Queen's University, Kingston, Ontario has announced the following faculty appointments:

Lynn Ashworth, (B.Sc.N., University of Western Ontario) as lecturer;
Faye Brooks (B.Sc.N., M.Sc.N., University of Toronto) as assistant professor returning to the faculty after a two-year absence;
Leta Burnfield (B.Sc.N., Queen's University; M.Sc.N., State University of New York at Buffalo) as assistant professor;
Ruth McKenzie (B.Sc.N., Roberts Wesleyan College, Rochester, New York) as lecturer;
Shirley Smale (B.Sc.N., Western Reserve University; M.P.H., University of Michigan) as assistant professor returning after one year's absence.

The Faculty of Nursing, University of Alberta has made the following faculty appointments:

Kathleen A. Dier (M.Sc., McGill University) as associate dean effective Sept. 1. For the past year, Dier has been on a one-year posting as a World Health Organization consultant. She worked with the Faculty of Public Health, Mahidol University, Bangkok, Thailand concerning the planning and implementation of a one-year Nurse Practitioner Diploma Program and a two-year Master's in Public Health Nursing program;
Patricia Lynne Brown (B.Sc.N., University of Western Ontario; Dip. Clinical Behavioral Sciences, McMaster University) as course leader in the fundamentals of nursing;
Donna Elaine Crozier (B.Sc.N., University of Alberta) as lecturer in community health nursing;
Roberta L. Kozley (R.N., St. Boniface School of Nursing; B.Ed. and M.A., University of Wyoming; Ph.D. University of Alberta) as associate professor;
Winnifred Claire Mills (B.Sc.N., University of Alberta) as lecturer;
Olive June Young (B.Sc., University of Alberta) as assistant professor.

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McMaster University School of Nursing in Hamilton, Ontario is pleased to announce the appointment of the following nurses to the faculty for the 1977-78 academic year:

Jo-Ann Tippett Fox, (R.N., Montreal General Hospital, B.N., U. of New Brunswick, M.Sc., Ph.D. (Physiology) Queen's University). In January, 1977, Fox received the first annual award for Student Research from the Canadian Foundation for Ileitis and Colitis. During her Ph.D. program, Fox was supported by an M.R.C. Studentship. She has also received a Fellowship from the Medical Research Council and is carrying out post-doctoral training in the Department of Neurosciences, Faculty of Health Sciences under Dr. E.E.Daniel.

Regina Bohn-Browne (B.Sc.N., Catharine Spaulding College, Louisville, Ky.; M.S., Boston; M.Ed., Ph.D. (Educational Theory ,Toronto). Browne has received a NHRDP Scholar award under the supervision of Dr. Dorothy Kergin, the associate dean of health sciences (nursing) at McMaster. Browne's research interests relate to the roles and utilization of nurses in primary care settings.

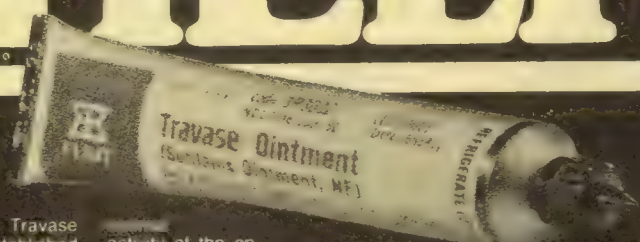
The following nurses have also been appointed to the McMaster faculty:

John English,(M.H.Sc., McMaster)
Esther Green,(B.Sc.N., Windsor)
Jo Anne E. Haynes,(B.Sc.N., Toronto)
Michael J. Lawrance,(B.S.N., U.B.C.; M.S.N., U. of Penn.)
Maureen Montemuro, (B.Sc.N., U. of Toronto)
Barbara Pine, (B.Sc.N., Queen's University)
Ann Schmitt, (B.S.N., Marquette; M.S.N. Indiana)
Catherine Tompkins, (B.Sc.N.,U. of Western Ontario)

Helen M. Evans (R.N., Toronto General Hospital School of Nursing; B.Sc.N., University of Western Ontario; M.S., Boston University) has been appointed president of the Council of the College of Nurses of Ontario. Evans is director of nursing at the North York General Hospital in Toronto. Prior to joining the hospital she was assistant director, professional standards, at the College of Nurses of Ontario. She succeeds **Una Ridley** who will now devote her time to duties as Acting Principal of the Kingston campus of St. LawrenceCollege of Applied Arts and Technology in Kingston.

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Things that go BUMP in the night

"From ghoulies and ghosties and long-leggety beasties
And things that go bump in the night,
Good Lord, deliver us!"
— Scottish prayer



If you've ever found yourself all alone at two o'clock in the morning, acting as troubleshooter for a mechanical device that spells the difference between life and death for a patient, then,this story is for you.

Organized nursing in Canada took its first shaky step in the direction of official partnership in the realm of electronic wizardry within the hospital environment in June of this year. I know because I was there. This is my report to the nurses I represented on that historic occasion.

Laura Worthington, *CNA representative at the International Conference on Medical Devices, Ottawa, June 14-16, 1977.*

Why were Canadian nurses represented at this type of seminar? I certainly wondered myself until I began mentally to tick off all the medical devices we depend on.

As an acute care nurse there is no end to the electrical gadgetry I cope with every day ... pacemakers, intra-aortic balloons, I-Vacs, transducers, monitors and respirators. These are just a few of the tools in our "trade." Would I like to have a say in how they are made, what safeguards are built into them and to understand a little better how they work? You bet I would! If you've ever found yourself in the situation I described above, you'll agree it is critical for nurses to acquire a working knowledge of these devices. Yes, we really needed to be at that convention ...

But what could I as a nurse contribute? Was my experience unique or valuable? Over and over I kept thinking, "well, the buck stops here. Who is better qualified to tell the people that conceptualize, construct and distribute equipment how it works than the nurse?" We know all the idiosyncracies of our machines, from a monitor that does an electrical fandango when you lean over the leads to a temperature probe that doesn't work unless it points due north. Yes, there were some points that nursing should make.

But when I approached the podium, the 200 expectant faces blurred and I suffered my usual pre-speech panic. What could I tell these doctors, bio-medical engineers, journalists, company presidents and sales representatives that they didn't already know about medical devices? How could I get the needs and concerns of our profession across to them without sounding maudlin or completely idiotic? I glanced at my few, brief notes, took a deep breath and began.

My talk was simple, direct and to the point. I stressed that the number of mechanical devices within hospitals had skyrocketed over the last few years. They have become so intimately connected with direct care of the patient that a mechanical device often indicates when a change in therapy is needed while another one may *be* the therapy indicated i.e. a monitor alerting the health care team to the patient's need for a temporary pacemaker.

Have nursing curriculums reflected their awareness of the profession's responsibility to know more about electrical devices? No, only on the Master's level am I aware of universities which offer courses in bio-instrumentation. I'm sure this will change but as yet it has not. And we need to understand now.

When an R.N. experiences a power failure (or similar calamity) on her unit she needs to know:

1. which machines are life-saving to the patient, and
2. how can she substitute for them until the problem is solved.

We need to have these answers from the people who bring mechanical instruments into the hospital environment— preferably *before* we are faced with a malfunction or similar "calamity." A!so, it is only natural that each machine should have its limitations; we should be aware of these before the patient is involved.

Which brought me to my second point. As a nurse, as someone who teaches nurses, I would like to see companies distribute modular teaching packages with their more complex equipment. Something like an audiovisual tape and slide show would be ideal. Every nurse on any shift could then learn or reinforce her skills by previewing it. And, as an afterthought, I stressed that there is no reason these teaching aids couldn't be made by nurses who have worked with a new piece of equipment in a controlled environment, and know its nuances.

Finally, I emphasized the need for more and better safety devices on existing equipment. Can you imagine a temporary pacemaker with a green light showing when the battery is new, an amber light showing half its life has been used and a red light coming on *before* it actually fails? This makes infinitely more sense than noting loss of capture on the monitor! This is only one of many ideas I believe the nursing profession could come up with if they were allowed to have a say in the type of machines they use.

Judging from the response, my audience was just as anxious to hear what I had to report as I was eager to tell them. I wondered why we hadn't made ourselves heard sooner. All nurses are involved with medical devices whether they are disposable syringes or intra-aortic balloons. We just don't realize how much a part of the whole picture we are.

I would like to share some of the things I learned at the conference with you. Did you know, for example, that:

- There is an emergency care research institute in the U.S. which checks out equipment before it is released to the consumer? This institute also
  - — issues hazard bulletins
  - — organizes educational seminars
  - — provides telephone and letter consults for on-the-spot answers to problems.

  The address is 5200 Butler Pike, Plymouth Meeting, Pennsylvania.
- *Health Devices,* a monthly publication of the Institute, constantly reviews and issues impartial reports on the quality of new equipment?
- R.N. representation on every hospital's standards committee is imperative as this is usually where new equipment is cleared?
- Health and Welfare Canada is in the process of establishing a central information and evaluation service for mechanical devices?
- Biomedical engineers in Vancouver have asked officials at U.B.C. School of Nursing to introduce a class on instrumentation?
- An education seminar on medical devices may be held in Montreal next year?

After three days in Ottawa I left with many positive impressions about the role of nursing in the future of medical device regulation. I believe that we must be in the forefront of future research and implementation. If we don't wake up and assume that position, we have no right to complain when "something goes bump in the night" and, in the wee hours of the morning, we can't figure out how to fix, operate or interpret that "dumb machine."

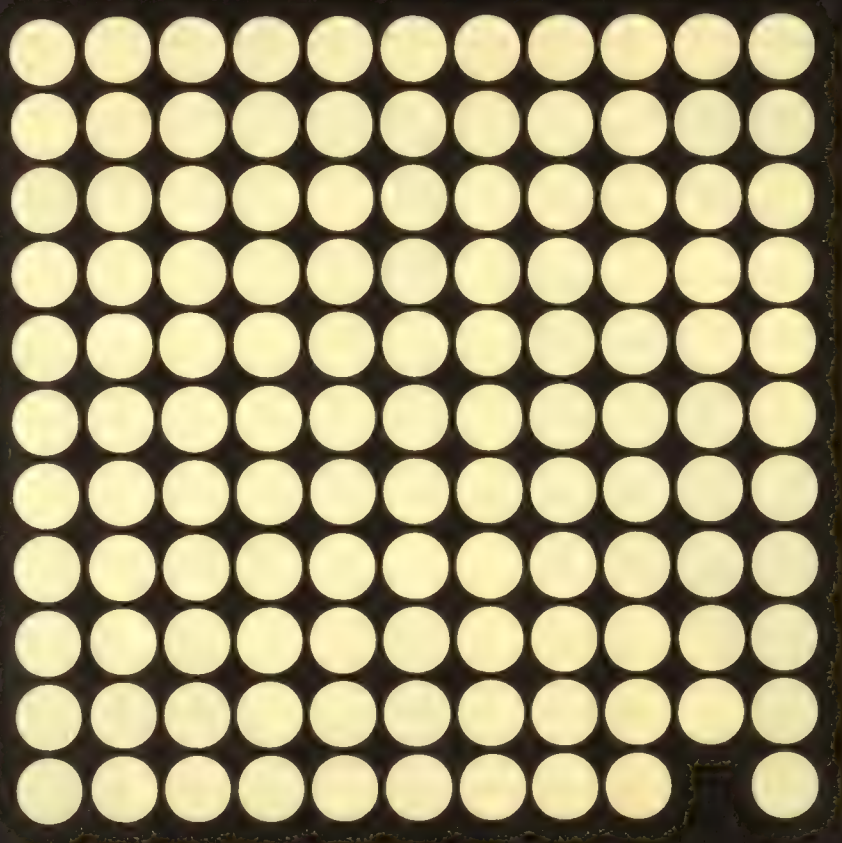
Author **Laura Worthington's** *experience in the intensive care setting is far-ranging. She has worked in units in Los Angeles, San Francisco, Vancouver and is presently a nurse clinician in the recovery room and ICU of the Royal Victoria Hospital in Montreal. She received her Bachelor of Science from the University of San Francisco in 1971 and her Master of Science in cardio-pulmonary medicine from the University of California in San Francisco in 1976.*

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GLAUCOMA

AWARENESS PREVENTS BLINDNESS



Glaucoma is the cause of blindness in one in ten of those who eventually go blind. In Canada, 100,000 people over the age of 35 have glaucoma; half of them are unaware of their condition. Many of them will find out about it only when it is too late. Like the "thief in the night," glaucoma works quietly, and often the victim remains unaware of the condition until the damage is done, until he is almost blind. Knowing about glaucoma is important — for nurses, and for the public — because it is common, because it causes blindness, and because early detection and treatment can prevent loss of eyesight.

Eileen French

Glaucoma is a condition in which the pressure inside the eye increases above the normal limit, an increase that may result in either temporary or permanent loss of vision.

Originally the word 'glaucoma' referred to the color change that characterizes acute or congestive glaucoma (a gray-green color, like "a stormy sea"). Now the term applies to all conditions in which there is increased intraocular pressure, so that the chronic form, which displays no color change, is also referred to as 'glaucoma'.

A normal intraocular pressure lies in the range of 16 to 21 mmHg, and any reading above 21 mmHg is considered pathological. When intraocular pressure increases above the normal, fluid (aqueous humor) is forced into the cornea, where it collects in tiny droplets. The person with glaucoma may notice blurring of vision because this build-up in fluid interferes with light rays passing through the cornea.

As intraocular pressure builds, blood supply to the retina is impaired. Unless measures are taken to prevent further increase, the retina and optic nerve are gradually destroyed. Undetected glaucoma can result in permanent atrophy of the optic nerve, and irreversible blindness. Early detection of the condition and medical intervention can prevent blindness.

For nurses, understanding what happens in glaucoma is an important step towards teaching others effectively about the disease. In order to understand the pathophysiology underlying glaucoma, we need first of all to review the structure and function of the parts of the normal eye. (See Table 1 and Figure 1).

Figure 1: Anatomy of the eye

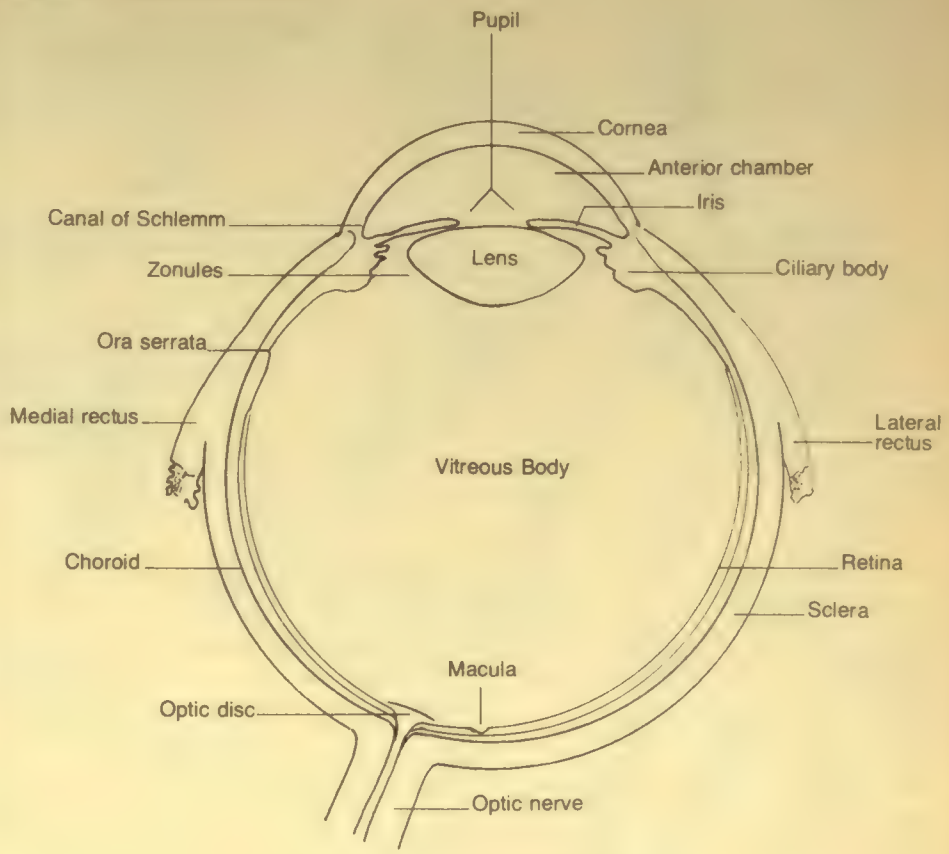


Table 1 Structure and function of the eye: a review

Structure	Function
1 Outer or fibrous coat includes:	
• the sclera — a tough fibrous tissue, the "white of the eye"	• preserves the shape of the eyeball • protects delicate inner layers
• the transparent cornea (in front)	• allows the passage of light rays to the retina
• the extrinsic muscles (attached to the sclera)	• permit and limit the movement of the eyeball within the orbit
2 Middle or vascular pigmented coat includes:	
• main arteries and veins of the eyeball	• nourish tissues of the eye
• the pupil	• the opening at the center of the iris for the transmission of light
• the iris — the colored muscular ring surrounding the pupil	• controls the size of the pupil and the amount of light entering the eye
• the ciliary body	• produces aqueous humor
• the ciliary muscle	• contracts and moves forward to aid in the adjustment of the eye for vision of near objects
• the suspensory ligament	• relaxes to allow curvature of lens to alter for accommodation for near vision
• the crystalline lens	• brings light rays to focus on light-sensitive retina
• the choroid	• forms the posterior 5/6 of the vascular coat
3 Inner or nervous coat includes:	
• the retina which lines the back of the eye and contains nerve receptors for vision	• a light sensitive layer • highly specialized to respond to stimulation by light • converts light energy into nerve impulses which travel along the optic nerve to the visual center in the occipital lobe of the brain

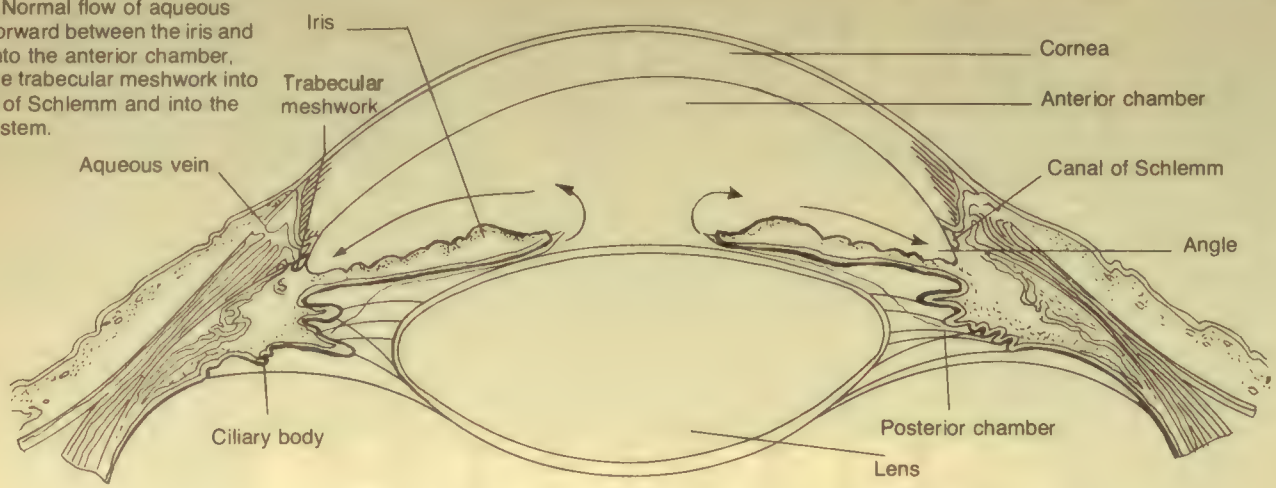


Figure 2: Normal flow of aqueous humor is forward between the iris and the lens into the anterior chamber, through the trabecular meshwork into the Canal of Schlemm and into the venous system.

Normal intraocular pressure

Intraocular pressure is determined by the rate of production of aqueous humor by the ciliary body, and the resistance to outflow of aqueous humor from the eye. In the normal eye, there is a constant balance between the rate of formation of aqueous humor and the rate of its absorption from the eye.

Aqueous humor, a crystal clear fluid, is formed by the ciliary body and fills the anterior and posterior chambers of the eye, permeating the vitreous humor. It serves as a refractive medium, provides nutritional support to the avascular lens and cornea, and contributes to the maintenance of intraocular pressure.

From the posterior chamber, the aqueous humor passes between the iris and lens to the pupil and the anterior chamber. A portion of aqueous humor then passes through the trabecular meshwork by diffusion into the Canal of Schlemm and out through the aqueous veins into the anterior ciliary veins. It is also absorbed by the vessels and the iris; some diffuses into the vitreous humor and leaves the eye by posterior drainage routes.

What happens in glaucoma

Most cases of glaucoma are caused by a block in the trabecular meshwork. The cause of this block is the feature that identifies the various types of glaucoma.

Secondary glaucoma is caused by a clogging up of the meshwork by blood, fibrin, inflammatory cells and debris, pigment etc., and is secondary to such causes as injury or infection. Other forms of the condition are known as primary glaucoma.

Chronic simple glaucoma or **open angle glaucoma** is the most common type of the disease. It is caused by a thickening of the meshwork itself as an eye with a hereditary predisposition to glaucoma becomes older. In chronic simple glaucoma, the trabecular meshwork is just not working. It may be compared to the blocked drain of a sink — the water goes through the sink but is blocked further down the drain; it may drain a little at a time, but eventually, it becomes completely blocked.

Congestive glaucoma occurs only in those uncommon eyes in which the iris is displaced abnormally far anteriorly. Because of this displacement, the iris presses against and covers the filtration meshwork. Congestive glaucoma may be chronic or acute; the angle between the iris and trabecular meshwork may be narrowed or closed.

Acute or **closed angle glaucoma** is a medical emergency. If it is not treated immediately, blindness may occur in three to five days. Using the blocked drain analogy, this type of glaucoma is like a sink that is full of garbage — the tap is open, but water cannot get to the drain.

Most often attacks are unilateral, and are characterized by a sudden rise in intraocular pressure, causing edema and congestion of the iris and ciliary process. The patient's eye is usually red in appearance, the cornea steamy, clouded and insensitive; the pupil dilated and sluggishly reactive. The patient may complain of blurred vision, see halos around lights, or have rapid loss of vision. He may also have excruciating throbbing pain accompanied by nausea and vomiting.

Diagnosis of glaucoma

How does a person discover that he has glaucoma? Unfortunately, many people do not realize that they have the disease until they cannot see. By this time, no treatment can restore their sight. Routine eye examinations, however, detect the disease early, and adherence to the prescribed treatment regime will maintain good vision. Chronic simple glaucoma is never discovered spontaneously by the patient himself until he is partially blind,

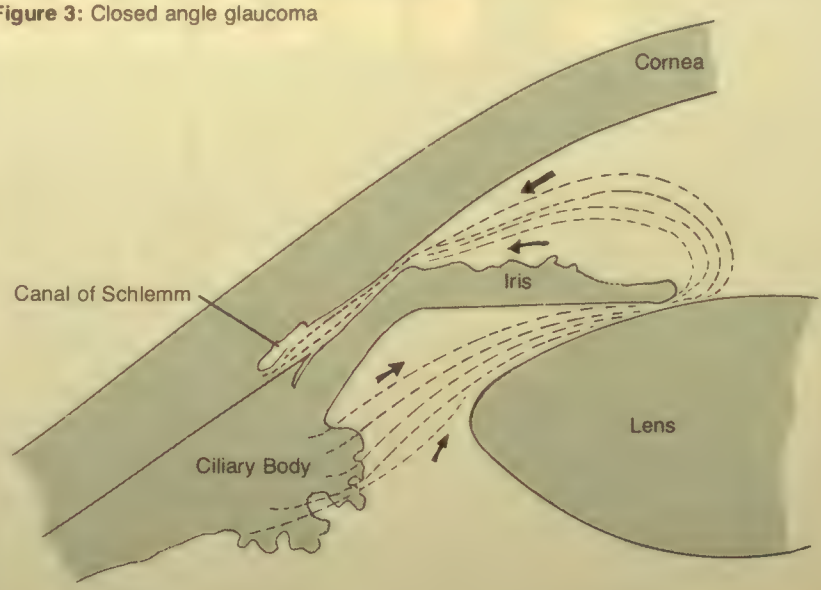


Figure 3: Closed angle glaucoma

because its influence on vision is very gradual. Symptoms are insidious and develop slowly. He may feel mild discomfort associated with the development of glaucoma, a feeling of tiredness in the affected eye. Impairment of peripheral vision occurs long before any effects are noticed on the patient's central vision, so that he may have problems bumping into things, or difficulty driving a car.

Late symptoms occur only after severe and irreversible eye damage takes place. Unless the patient develops acute angle glaucoma, the disease process is not accompanied by pain, redness of the eye or any alarming appearance. It is only through a few simple diagnostic tests that the disease can be discovered early enough to prevent blindness.

Intraocular pressure may be measured painlessly, easily and safely by tonometry. Although there are a number of different tonometers in use, the most common are the Schiotz Tonometer and the Applanation Tonometer.

The Schiotz Tonometer

The Schiotz Tonometer indents the cornea by slight pressure. If the patient's intraocular pressure is high, the cornea will resist indentation more than if the pressure is low.

The test itself is simple. The patient is placed on a table or tilted back on an adjustable chair, and instructed to look straight up. A single drop of anesthetic (ophthaine 0.5%) is instilled into both eyes to produce corneal anesthesia within a minute. The sterile tonometer is then placed gently upon the center of the cornea for several seconds, during which the scale reading is determined.

The Applanation Tonometer

The Applanation Tonometer measures the force required to flatten rather than indent a small area of the central cornea. This tonometer fits on a slit lamp. The patient is seated in front of the slit lamp and the tonometer is placed in front of the right or left eye. Both eyes are anesthetized and stained with fluorescein. The patient's chin is placed on a chin rest with his forehead pressed firmly against the supporting bar. This tonometer gives the most accurate measure of intraocular pressure obtainable clinically.

After examination by tonometry, the patient is cautioned against rubbing his eyes for about fifteen minutes, because the corneas are still anesthetized and could be painlessly abraded.

Other tests

- Gonioscopy is another diagnostic test used in the diagnosis of glaucoma. It consists of a biomicroscopic examination of the angle of the anterior chamber. This test is necessary for diagnosing the type of glaucoma the patient has. Preoperatively, this examination helps to determine which eye is in danger of angle closure and which is safe from closure, and defines the cause of secondary glaucoma. In the case of angle closure glaucoma, gonioscopy is used postoperatively to evaluate the success of an iridectomy in opening the angle.
- Perimetry is used to measure the peripheral fields and will delineate any loss of vision from glaucoma.
- Tonography is the recording of the intraocular pressure on a graph (similar to the electrocardiogram) over a period of four minutes. This is a valuable test for the ophthalmologist to use in determining the adequacy of the trabecular drainage systems.



Photo courtesy of Photographic Services, Notre Dame Hospital, Montreal

Measuring intraocular pressure using the Schiotz Tonometer.

Treatment

The treatment of glaucoma varies with the type and severity of the disease. Fortunately, the great majority of early diagnosed cases respond well to medical therapy; advanced cases often fail to be controlled by either medical or surgical means. Once the diagnosis is confirmed, treatment must begin at once.

The ultimate goal of treatment for any type of glaucoma is to reduce intraocular pressure. In most cases, the instillation of *miotic drops* several times daily will control the pressure adequately. Miotic drops, the most commonly used being pilocarpine, constrict the pupil to facilitate the outflow of aqueous humor by increasing the efficiency of the outflow channels. The concentration and frequency of the dosage to be used by the patient is gradually regulated by clinical trial.

Miotic drops do not cure glaucoma; the patient must use these drops daily for the rest of his life, just as a diabetic must remain on

insulin therapy. He must not neglect to use them.

Another medical method used to control intraocular pressure is through the use of an oral medication, a *carbonic anhydrase inhibitor,* most commonly, diamox. This drug acts to reduce the rate of formation of aqueous humor by the ciliary body.

In the case of acute angle closure, surgery is imperative, once the patient's intraocular pressure is lowered to a safe level. A *peripheral iridectomy*, usually done under a local anesthetic, is one method of surgical correction. This procedure creates a hole in the iris, a new channel to enable aqueous humor to flow from the posterior to the anterior chamber.

An *iridencleisis* is the surgical procedure used to create an opening between the anterior chamber and the space between the conjunctiva. This opening bypasses the blocked meshwork and enables aqueous fluid to be absorbed into the conjunctival tissues.

For chronic open angle glaucoma, a *corneoscleral trephining* is the usual surgery performed. A permanent opening is made at the junction of the cornea and sclera through which aqueous humor may drain.

Whether the treatment of glaucoma is medical or surgical, the nurse has a responsibility to create a climate of awareness about the disease, and to teach the patient what he should know about glaucoma and its treatment.

The role of the nurse

The nurse's responsibility begins with knowledge. With a thorough understanding of the pathophysiology of glaucoma, she is in a good position to help educate individuals about the disease and its potential to cause blindness. It is especially important for her to help educate those whose age (over 40) or family history might indicate a need for screening. Her knowledge of the location of glaucoma screening clinics and the necessity for frequent checkups can be a help to those needing guidance.

Optometrist, Optician, or Opthamologist?

Many individuals simply do not understand the functions of those who call themselves eye specialists. Recognizing this fact, the nurse ought to clarify the roles of different eye specialists and direct people intelligently for proper care.

It is important for people to know that the *opthamologist* (also referred to as an oculist) is a medical doctor, skilled in the treatment of all conditions and diseases of the eye. Because of his specialized training, his experience, and the availability of specialized equipment, he makes a thorough and complete eye examination. In addition, he prescribes medication and does eye surgery.

On the other hand, the *optician* is not a physician. His specialty is in grinding, mounting and dispensing lenses. Again, the *optometrist* is not a physician, but is licensed to examine the eyes for refractive errors by



Author Eileen French has her intraocular pressure measured by the Applanation Tonometer.

mechanical means, and to provide appropriate corrective lenses. The optometrist does not use eye drops in his examinations.

The nurse can recommend that an individual have a thorough eye examination by an opthamologist to screen for glaucoma.

An informed nurse can also help to explain to individuals the types of tests that they need to undergo in order to rule out or confirm a diagnosis of glaucoma, emphasizing that these tests are painless and simple.

Glaucoma cannot be cured, but it can be controlled to a large degree whether the patient has surgery or not. The great majority of early glaucoma cases respond well to medical therapy. The nurse can play an important teaching role in helping the patient to understand this therapy.

The patient with glaucoma must know just how important it is to use miotic drops in his eyes (as prescribed by a physician) every day, for the rest of his life, even after surgery. The nurse needs to emphasize that he must never neglect to instill the drops, that intraocular pressure is controlled only as long as therapy is maintained.

It is also important for a nurse to be aware of the action and adverse effects of the drugs, so that she can properly instruct the patient, answer any of his questions, and reinforce the physician's instructions.

Pilocarpine, the most commonly used miotic, has a relatively short duration of effect and must therefore be instilled several times a day. The patient should be instructed to store the drug in a light resistant container. It is a help to the patient to be made aware that he may experience some dimness of vision for a short time after instilling the drops.

Although adverse reactions to pilocarpine are rare, prolonged use of the drug may increase their incidence. Symptoms such as darkened vision, blurred distant vision, aching in the eyebrows or head, excessive salivation or sweating, or nausea and abdominal cramps, should be reported to the patient's doctor as they may signify the onset of systemic toxicity.

The instillation of eye drops is a simple task, but a patient or members of his family may appreciate a demonstration of the correct method.

If the patient is prescribed a carbonic anhydrase inhibitor such as diamox, he should also be aware of the action of this drug. Diamox inhibits the action of an enzyme necessary for the production of aqueous humor. Because it slows the production of aqueous humor, intraocular pressure is reduced. The medication is taken by mouth and is well absorbed from the gastrointestinal tract. As a side effect, diamox increases urinary flow.

Normally, surgery is used only to alleviate acute angle glaucoma or cases of glaucoma that cannot be controlled by medical means. Immediate pre and postoperative care of the patient undergoing eye surgery is determined by the type of operation done, the anesthetic used, and the patient's age and state of health.

The prospect of any type of eye surgery can be a threatening experience for a patient because he faces the fear of blindness. The patient's fears can be alleviated to a certain extent by a nurse's explanation of what is going to happen to him and what is expected of him, as well as her answers to questions and concerns that he may have.

Most patients have some type of trephining procedure done; they will return to their room with both eyes bandaged and will usually be kept flat and relatively quiet for the first 24 hours post-op. Patients are usually encouraged to turn towards the unoperative side, and to restrain from straining, coughing, squeezing their eyelids or any other activity that could cause an increase in intraocular pressure.

Whether a patient is treated medically, surgically, or both, a good teaching plan is essential if he is to understand his disease and its treatment. There are also many common misconceptions that a nurse can help to clear up. So often the patient with glaucoma will restrict himself unnecessarily because his source of information is an overcautious friend or relative who lacks knowledge about the condition.

The patient should understand that it does not harm him to use his eyes as usual, although he may feel fatigued more quickly than a normally sighted person simply because his vision is impaired to some degree. This is due to muscle fatigue, and rest helps. But he needs to know that he cannot "save" his eyesight by using his eyes less; in fact, it has been shown that aqueous outflow is slightly improved during reading.

Another common misconception that needs clearing up has to do with fluid intake. There is no logical reason for a person with glaucoma to restrict his fluids; drinking under normal circumstances does not increase intraocular pressure. Rarely, a person will show an elevation of intraocular pressure when he drinks coffee. A test can be done using a tonometer before and after drinking coffee to determine its effect on each individual patient; if it doesn't affect his intraocular pressure, then there is no reason for him to stop drinking coffee. It has also been shown that eye pressure is not significantly changed by smoking or drinking alcoholic beverages.

General physical exercise is not harmful to the patient with glaucoma; in fact, it is necessary to promote good circulation and elimination. Maintenance of regular bowel habits prevents straining and a resulting increase in intraocular pressure.

Use of medications taken for other diseases, with the single exception of the atropine-like drugs will not interfere with the treatment of glaucoma. Patients should carry a card stating they are being treated for glaucoma because the use of a mydriatic such as atropine could be very serious to them, especially for the patient who has shallow angle closure.

Tight clothing, tight belts, collars or girdles, do not increase intraocular pressure. Heavy lifting, with the possible exception of weight lifting does not increase intraocular pressure.

It is a common belief that there is a relationship between vascular hypertension and ocular hypertension (glaucoma), but such is not the case.

A person who has been diagnosed as having glaucoma should be aware of the absolute necessity of using prescribed eye drops and the need for frequent checkups for the rest of his life. He should also know that he does not have to become crippled. Although he may have some limitations, he can also expect to live a normal, productive life. The key is early detection, proper treatment and continued follow-up. A nurse who is aware of glaucoma and what it means, who knows how to apply her knowledge and is willing to do so at every opportunity, is the nurse who holds this key.

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FOUR SCORE AND TEN

This is the first in a three-part series of excerpts from the unpublished memoirs of Maude Wilkinson, a Canadian nurse for 47 years. Maude is now ninety-five years old and living in Sunnybrook Medical Centre's Extended Care Facility, Toronto. This first part describes Maude's entry into nursing. Next month she looks at her experiences as a Nursing Sister in World War 1 and finally she remembers the time she spent with the Red Cross Outpost Service and as a superintendent of a nursing home.

Maude worked in various facets of nursing from 1912 to 1959. We believe that in many ways her unique history captures the flavor of those early years of nursing and serves as a personal account of the evolution of our profession in Canada.







In the early afternoon of November 28, 1882, Emma Elizabeth Wilkinson gave birth to a frail little girl. The baby breathed with difficulty, was properly spanked, wrapped in a blanket and placed in the oven of the kitchen stove.

John Wilkinson, husband, "doctor" and "midwife" watched the new mother very anxiously — it had been a long, hard labor and a difficult delivery. His wife was exhausted.

Later the baby was taken out of the 'improvised incubator,' washed and placed in her mother's arms. This is the story of that baby, Maude Wilkinson.

Maude Wilkinson



Many of my early years were spent moving around North America. My father was a minister and this meant a great deal of travelling for my family. But Toronto was still home and it was to Toronto that we kept returning.

My mother, sister and I made two trips overseas visiting large European centers in the early 1900's. It was after one of these trips that I began to consider entering the work force.

I was 27 years old in 1909 and still completely dependent upon my mother for support. A financial discussion with my father made me realize just how unfair this was. My health was good and I was certainly physically capable of taking care of myself.

I decided something had to be done, but what? How could I begin to support myself?

Nursing had appealed to me for a long time. I had read a lot about the life of Florence Nightingale and of what she had accomplished in the Crimea. These accounts intrigued me and to a great extent influenced my decision to enter the profession.

Actually, nursing had been in the back of my mind for quite a while. While we were visiting London, England in 1907 I went to St. Thomas's Hospital and asked to see the Matron. When I asked her about their nurse training program she was curious to know why I was considering St. Thomas's. She said that she knew we had several good schools of nursing in Canada. I had to confess, sentimentally, that it was because Florence Nightingale had been so closely connected with her hospital.

The Matron explained to me that her school accepted two types of students — those who were able to pay for their training (I don't recall the amount) and those who did not pay. Although both of these groups were given the same course, the latter had to do a good deal of the menial work, such as cleaning and scrubbing. Matron said she could see that physically I would not be able to do the work required of the non-paying group and asked if I would consider paying. I thanked her and said that I would think the whole situation over.

Upon our return to Toronto I had an interview with Miss Lash, the superintendent of the Cottage Hospital on Wellesley Street. Much to my embarrassment Miss Lash asked me the same question, "Why are you thinking of entering my training school?" She pointed out the fact that although her school offered a good practical course, graduates were not eligible for provincial registration.

Once again I had to confess to sentiment. The Cottage Hospital occupied the house my grandfather had owned, the house where my mother was married.

Miss Lash was very understanding, but she told me that in the long run it would be to my advantage to enter a training school connected with a large general hospital. Later I realized just how important her advice was and I have always been very grateful for it.

At first Mother's sisters were quite disturbed by my decision to be independent and support myself. No female member of the family had ever thought of such a thing, let alone attempted it. The fact that Florence Nightingale had been from such a prominent English family and was so highly respected for her work finally won them over.

Many Toronto women were taking their training at Roosevelt Hospital in New York City, so I applied there. I knew I would miss being with my family, but Mother and my aunt were planning to be together so they didn't need me.

My application was accepted and I was included in the class of 1909.

Training

I left for New York in November of 1909. The girl I sat beside while on the train was also entering the fall class. This trip together sparked a warm friendship that lasted until my



friend's death a few years ago.

Our first three months of training were very difficult. We were probationers and had to earn our caps. Those not qualifying had to leave.

We worked very hard; twelve hours a day with only two hours off for breaks. Our time off included one half day a week from 2:00 to 10:00 p.m. and every other Sunday afternoon beginning at 2 o'clock.

As students we would gather together at night, very tired, but happy. We would chat and relate to each other the events of the day.

There were some funny experiences to laugh about. I remember the story of the girl who was told to clean the dentures of some thirty patients on the ward. Feeling very honored to be selected for this task, she collected all of the patients' teeth in a basin and proceeded to the utility room to wash them!

Needless to say, nobody was very impressed and this probationer did not earn her cap, she had to go home. Even up to the day they left the hospital some of her patients swore their own teeth had never been returned to them.

My roommate at Roosevelt was a Toronto girl. She was my 'senior' and her authority had to be recognized. For example, if we were both leaving the room at the same time I was expected to open the door and step aside until she passed through.

As I look back on those years I remember one particularly special night. A girl in the graduating class learned the Superintendent's birthday was the next day. She also knew the chef had baked a special cake and where he had put it for safekeeping.

To the chef's surprise that cake somehow disappeared through the night. We students had a grand party with all thoughts of seniority forgotten — we were all in this together. Poor Miss Samuel, our dignified superintendent, was wished many, many happy returns the next day, but the chef never found her cake. (It was delicious!)

We received our obstetrical training at the Sloane Maternity Hospital across the street from Roosevelt — 59th Street and Madison Avenue. The hospitals were located in a predominantly black district of New York. All of the students loved those little babies; they were so sweet.

During my three years of training I was never once able to go home, there just wasn't enough time. I was never ill, except to have my appendix out. I had been having a lot of trouble with indigestion. My appendix was blamed and therefore removed.

Oddly enough, after my operation the chief surgeon was heard to remark to his students, "The appendix was normal you know, but the ten days rest will be good for her." The first night I was allowed one hypodermic 1/4 grain of Codeine. No other sedative was administered at any other time during my recovery period. The ten days I lost recuperating had to be made up before graduation.

Upon commencement I was offered a nurse-in-charge position at both Roosevelt and Sloane, but I wanted to go home. During my last year I had written to Dr. Herbert Bruce in Toronto, he and Sir William Mulock had founded a hospital on Wellesley Street. I reminded Dr. Bruce that he had met me at my uncle's wedding and asked if there would be a position for me at his hospital when I graduated.

I received a reply almost immediately. I was to report to the superintendent of nurses as soon as I arrived home!

Wellesley Hospital: my first job

Wellesley began in a large house on Homewood Avenue off Wellesley Street. The rooms on the ground floor were large. The doctors had kept enough of the original drawing room furniture to furnish one room. This room was shown to prospective patients along with assurances that when they were admitted all of the 'proper' hospital furniture would replace what was there.

When a patient decided to enter our hospital for treatment the 'unsuitable' furniture was moved out into another room which would then be set up for the next prospective client.

Needless to say, Wellesley catered to wealthy private patients and soon became very popular among that elite class. Some of the larger public hospitals were indignant because they didn't think Toronto needed another hospital, especially one such as ours.

I wonder if Elisabeth Flaws, the first superintendent at Wellesley is ever remembered? She was an energetic woman who worked ceaselessly from early in the morning to late at night. Her assistant, Miss Ferguson, and I often stayed on to help her with the extra work. Wellesley owes a great deal to Miss Flaws' organization.

At first I was put in charge of the ground floor but when the rooms there were filled, I was moved to the second floor. We had more rooms on the second but they were smaller than the ones downstairs. The staff lived on the third floor of the house until the nurses' residence was built years later.

Preparing for War Duty

The Canadian Government sent the first medical unit overseas in 1914. Miss Ferguson and I discussed enlisting for army service should a second unit be required. Our opportunity came in 1915 when Number 4, Canadian General Military Hospital was organized in Toronto. We decided to enrol for service. Miss Flaws was very annoyed, but Dr. Bruce was pleased that "his hospital" would be represented overseas.

Miss Gunn*, the superintendent of nurses at Toronto General Hospital had been appointed to enrol graduate nurses for enlistment. We filled in our application forms and presented them to her.

Miss Gunn took note of the fact that both of us had been trained in the United States; Miss Ferguson in Battle Creek, Michigan and I at Roosevelt. We both told her we were born in



Canada and had been employed in a Canadian hospital ever since we'd received our provincial registration. In spite of this our applications were not accepted.

On our return to Wellesley we told Sir William Mulock, the President of the Hospital Board, and Dr. Bruce, the Chief Surgeon, all about our experience. They were infuriated to have members of their hospital staff not considered eligible. Dr. Bruce wrote a letter to his friend, General Sir Sam Hughes in Lindsay, right away.

Word was received for us to apply again. We did, and our names were added to the list at once.

It is quite possible both Military Headquarters and the University of Toronto were not aware of this practice. Toronto hospitals disliked nurses not trained in Toronto hospitals and, therefore, discriminated against them. We heard from other nurses who had experienced the same kind of treatment. For a long time, even overseas, we were considered "outsiders." As a result we too became clannish and called ourselves "The Odds and Ends."

Time passed very quickly. There were so many things to be done. There were fittings for our long navy dress uniforms and for our blue cotton service uniforms. The service uniforms were worn with voluminous white aprons, muslin veils, ankle length navy cloth coats and unbecoming navy blue hats. Looking at the group photo taken before we left makes it clear, no anxious father had to warn his daughter to beware of the men overseas. In those uniforms even the most adventurous male would hesitate before casting an amorous glance in our direction.

We also had to attend military drill. A senior sergeant yelled the commands at us as we lined up, stepped out, marched and stood at ease.



I remember one morning in particular, it was raining and we all arrived with umbrellas. You can imagine the strictly military Sergeant's reaction to this display of femininity. "Put down the umbrellas, roll them and use them as canes," he barked with annoyance.

There were many social events planned for us which we were required to attend, punctually. Sir Henry and Lady Pellatt entertained all of us for tea at their new home, "Casa Loma." There was plenty of room for 73 nursing sisters in the 'Great Hall' where tea was served.

Dr. and Mrs. Bruce entertained Miss Ferguson and I for dinner with senior Wellesley graduates.

Altogether there was not much time left for family gatherings or going-away parties. May 15th came all too soon and we had to report to Exhibition Park for our departure.

I expect there have been gatherings on the Canadian National Exhibition grounds far more important than ours, but surely none could have been more unusual. There were officers, with their wives and families, nurses and their families and friends, administration people and many, many other personnel with their friends, wives and children.

Irrespective of rank, officers and men carried their babies in their arms. The little tots hanging onto them couldn't have known what was going on but they could sense something was wrong. Daddy was going away, they didn't know why or where, but they weren't going to let go of his hand.

Arrangements had been made for mother, my sister, several aunts and myself to be driven out to the grounds. We all stood together, not knowing what to do or what to say. There were promises to write often, to take care of myself, to come back soon — and endless admonitions. Poor old George; he had been grandfather's coachman for years and when it was time for me to leave he wrung my hand and cried, "Good-bye Miss Maudie; come back soon!"

I shall never forget my dear mother's face, anxious and bewildered, controlling the tears which I knew she would shed as soon as I left.

Then the call went up, "All aboard!" There were whistles shrieking, bells ringing and porters slamming doors; in the midst of all of this chaos, we were off.

The University of Toronto Unit, No. 4 Canadian General Military hospital left the Canadian National Exhibition grounds in Toronto very early on the morning of May 15, 1915. Destination ... unknown.





A sunny day

* Jean Gunn, was president of the Canadian Nurses Association from 1917 to 1920 and was convenor of the CNA Committee charged with erecting a memorial to the Nursing Sisters of Canada. The memorial, which is located in the Canadian Parliament Buildings, was unveiled in 1926.



Anatomy of a Death

Tonight
a man was dying
I felt his life
as it slid away
I watched
the fear
in your faces,
coupled
with the drama.
You were very
well versed
in pathology
you taught me
very well,
but I couldn't
take away my eyes
from his door.

I heard you
recite
the stages of his
death
and I listened
as he must have —
in anger,
for just as he must
have feared you
so I did.
I hated you
as he must have,
because the death
you felt was yours
not his
Then because
I wanted
to feel
I went inside his door
and all he was,
was real.



As a rule, CNJ does not publish poetry. We made an exception in this case because we feel the author expressed some of the feelings that we all have at least once in our working life. In a letter to us, Carole Estabrooks made her own case for publication:

"I wrote this poem on February 1, 1977 while I was a senior nursing student at the University of New Brunswick in Fredericton. I was working in a Coronary Care Unit at that time. This was my first exposure to the unit, it was also my first exposure to death. I wrote the poem to help me resolve my own personal conflicts.

I had not originally intended to submit the piece for publication but one of my professors encouraged me to share it in the hope that it would get across a point we, as nurses, can far too often ignore in a clinical hospital setting."

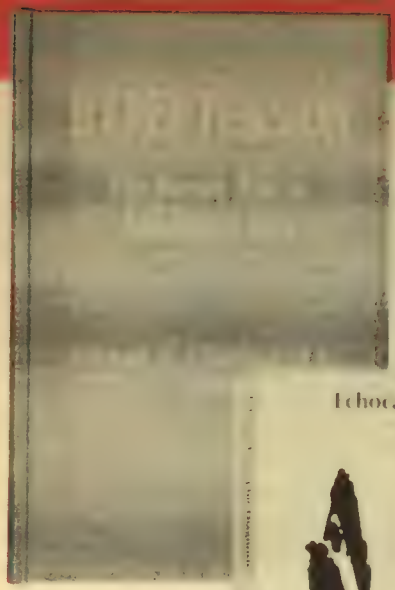
Since February, author **Carole Estabrooks** *has graduated from the University of New Brunswick, written her registration exams and assumed a full-time position on a Coronary Care and Intensive Care Unit.*

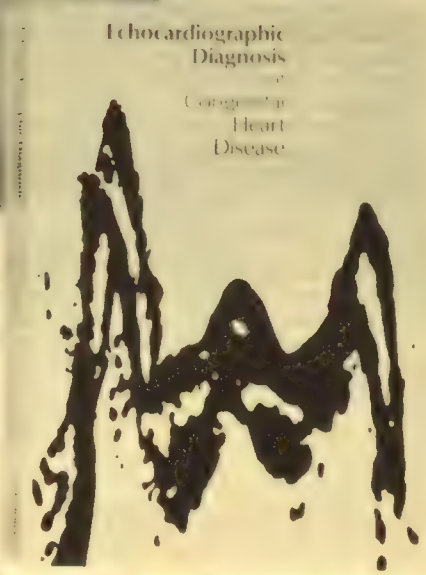
I touched him
it didn't hurt
I didn't cry
there was only
sadness
so deep
I cannot understand.
It's funny
you know,
we left him
alone —
a man became our failure
we turned away
and watched
his life as it
bleeped
across the screen.

You never touched
this man
You weren't there
to hold his wife
instead you
asked
the learned man
to diagnose
your grief
I walked away
in shame,
and it was worse than
I had thought,
because
I too
could see
my death
and still
I couldn't share.
I sat inside
a tiny room,
my hatred
surely showed
except now you
could never see
the reasons
for my words.

I do not understand
these tears,
I hardly knew
this man
except inside
a part has changed —
to watch a man
die alone,
his family grieve
alone,
to run away
because I feared
I'd never fill
the space.
My life goes on
as it always has
except there'll
be one change
I'll never run away again.
You see —
he squeezed
my hand.

— Carole Estabrooks





1 HYPERTENSION: The Nurse's Role in Ambulatory Care

How does the nurse become a hypertension specialist? Who is going to educate the nurse? This volume evolved from a recent intensive workshop held at Cornell University Medical College. The workshop was designed to supply the nurse with the physiologic and pathologic background necessary for understanding basic vascular diseases; to supplement physical examination skills to permit more detailed evaluation not only of the severity of the disease but also of the patient as a whole; to provide the pharmacologic background for use of antihypertensive agents; and perhaps most important, to emphasize the value of the team approach in long-term therapy and patient compliance. In sum, its goal was to prepare the nurse to be a pioneer in preventive medicine. It is hoped that this book will help promote the process.

By **M. H. Alderman**, *M.D.*

Springer **174 Pages** **Illustrated** **1977** **$12.00**

2 ECHOCARDIOGRAPHIC DIAGNOSIS OF CONGENITAL HEART DISEASE

An introduction to the field of pediatric echocardiography, this book provides a standardization of echocardiographic examination technique and interpretation. Each chapter includes an introduction to the anatomy of a lesion, followed by discussion of the relevant examination techniques, diagnostic features, pitfalls of diagnosis, differential diagnosis, case examples, and references.

By **R. G. Williams**, *M.D.; and* **C. R. Tucker**, *M.D.*

Little, Brown **352 Pages** **Illustrated** **1977** **$21.00**

From Lippincott . . .

3 QUICK REFERENCE TO CARDIOVASCULAR DISEASES

Here is authoritative, easy-to-find, clinically relevant data, presented in a special, time-saving format. Each entry is numbered and step-by-step instructions are given in outline form.

Dr. Chung and his many eminent contributors summarize their years of experience in this manual, covering *all kinds of cardiovascular disease:* vascular, valvular, endocardial, myocardial, and pericardial diseases, arrhythmias, drug-related disorders, cardiovascular disorders in systemic diseases, etc.; *all aspects of each disease:* general considerations, definition, etiology, pathophysiology, classification, signs and symptoms, complications and prognosis; *all phases of medical care:* history taking, laboratory findings, diagnosis, differential diagnosis, and management.

By **E. K. Chung**, *M.D., F.A.C.P., F.A.C.C. With 33 Contributors.*

Lippincott **469 Pages** **Illustrated** **1976** **$21.75**

4 CARDIOSURGICAL NURSING CARE: Understandings, Concepts, and Principles for Practice

The widely published author on technology in health care, recipient of numerous professional honors, answers the two-fold question: What is good nursing?; in particular what is good postoperative nursing care of the cardiac patient? Cardiovascular surgical nursing is presented in terms of 1) the "why" for nursing intervention; 2) the "what to do"—i.e., nursing actions to solve the patient's physiologic problems; and 3) the "how"—suggested nursing procedures.

By **R. K. Chow**, *R.N., Ed.D., F.A.A.N.; and* **E. C. Lambertsen**, *R.N., Ph.D.*

Springer **386 Pages. Illustrated** **1976** **$20.50**

5 SELF-ASSESSMENT IN ELECTROCARDIOGRAPHY

Here is a fully illustrated review of simple and complex electrocardiographic studies which will provide the reader with a practical tool for assessing and improving his knowledge of electrocardiography. The one hundred actual full-sized electrocardiograms included cover a wide range of rhythm and pattern abnormalities frequently encountered in the adult patient. Each electrocardiogram is followed by a brief history of the patient and a number of pertinent multiple-choice and true-false questions designed to stimulate the reader's thinking and containing clues for the correct interpretation of the tracing.

On the reverse side of each page the same electrocardiogram appears again, this time with the addition of appropriate labeling and superimposed Lewis ladder diagrams. This format allows for rapid identification of the ECG waves and the time intervals between waves as well as for a clear picture of the site of impulse information and of the electrophysiological mechanisms involved. The answers to the multiple-choice and true-false questions are then given so that they may be reviewed in conjuction with the annotated cardiographic tracing. In this way the reader can quickly compare his interpretation with the correct diagnosis of the condition.

By **S. Mangiola**, *M.D., F.A.C.C.*

Lippincott **About 210 Pages** **Illustrated** **1977** **About $20.00**

6 CARDIOVASCULAR NURSING: Prevention, Intervention, and Rehabilitation

This book describes the means of assessing heart function, current methods of treatment, and rehabilitation of patients with chronic heart disease.

By **J. Holland**, *R.N., M.S.*

Little, Brown **233 Pages** **Illustrated** **1977** **$7.75**

7

INTENSIVE CARE

All members of the health team who assume responsibility for patient care in and out of the intensive care setting will applaud the practical approach and explicit discussions that Intensive Care provides.

"This is the most complete compendium on intensive care of the surgical patient to come to this reviewer's attention. While the book is clearly slanted toward the problems in care of the critically ill 'surgical' patient, the majority of its chapters apply equally to the problems of intensive care of patients from any specialty group . . ." — *Annals of Surgery*

By J. J. Skillman, *M.D.*

Little, Brown **609 Pages** **Illustrated** **1976.** **$27.50**

8

HANDBOOK OF CRITICAL CARE

A concise presentation of how to cope with problems commonly encountered in the intensive care setting. The first section of the book is geared to the step-by-step solution of practical problems in respiratory and hemodynamic monitoring, cardiac and renal dysfunction, and blood component therapy, which occur daily with critically ill patients. In the second section, the authors describe the newest concepts and most recent advances in the field, such as the uses of computer techniques, intra-aortic balloon counterpulsation, and the membrane oxygenator in respiratory failure.

Edited by J. L. Berk, *M.D., et al.*

Little, Brown **574 Pages** **Illustrated** **1976** **$13.75**

11

THE PATIENT IN THE CORONARY CARE UNIT

This book was written primarily for the CCU nurse in the community hospital, where lack of elaborate monitoring apparatus means the nurse must rely mainly on clinical skill and judgement for detecting critical changes in the patient's condition. By the same token, coronary care nurses everywhere will welcome the many electrocardiographic illustrations of possible cardiac abnormalities. The physiologic basis of the discussions affords clear understanding of the causes of coronary complications and of the effect of drugs and other forms of therapy.

By H. Sweetwood, *R.N.*

Springer **465 Pages** **Illustrated** **1976** **$17.00**

12

MANUAL OF CORONARY CARE

A concise, spiral-bound manual for physicians, nurses, medical students, and physicians' assistants. It offers background material and general information needed in every situation encountered in the CCU and then supplies step-by-step protocols for handling them. Practical and current topics include management of unstable angina, cardiogenic shock, and congestive heart failure, and important new information on myocardial imaging, serial roentgenographic changes of pulmonary vascular congestions, and hemodynamic monitoring.

By J. S. Alpert, *M.D.; and* G. S. Francis, *M.D.*

Little, Brown **150 Pages** **1977** **$9.95**

for the Practitioner

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PATIENT CARE IN CARDIAC SURGERY, 2nd Edition

Completely revised and updated, this practical manual details current methods for caring for patients before, during, and after cardiac surgery. Written for nurses on the cardiac care service, house officers, and physicians, it reflects the extensive experience of the authors at the University of Michigan Medical Center and the Massachusetts General Hospital. Topics covered include preoperative, intraoperative, and postoperative management, postoperative complications, and special treatment problems encountered in children and infants requiring cardiac surgery.

By D. M. Behrendt, *M.D.; and* W. G. Austen, *M.D.*

Little, Brown **179 Pages** **Illustrated** **1976** **$10.95**

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AN INTRODUCTION TO ELECTROCARDIOGRAPHY, 5th Edition

The basic design of this book remains essentially the same as that of the previous editions. It is directed primarily to the beginner, and its aim is simplicity. The emphasis remains on deductive rather than empirical electrocardiographic interpretation. The whole text has been appreciably revised. The sections on P wave axis, potassium effect, A-V block and the Wolff-Parkinson-White syndrome have been significantly expanded. New sections have been added on idioventricular tachycardia, idionodal tachycardia, hypothermia, ventricular flutter and the action potential of pacemaking and non-pacemaking cells. Many of the illustrative electrocardiograms have been replaced and new ones added.

" . . . a masterpiece of exposition and teaching, and deserves very wide circulation at all levels of the profession concerned with electrocardiography." — *British Journal of Hospital Medicine*

By L. Schamroth, *M.D., D.Sc., F.R.C.P., F.A.C.C., F.R.S.*

Blackwell **240 Pages** **Illustrated** **1976** **$9.50**

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Almost 60 million women in the world became mothers in 1975. Thirteen million of those women were still in their adolescent years. In Canada in 1973, 39,852 babies were born to mothers who were not yet 19 years old. Among these teenage mothers 14,013 gave birth to illegitimate children. These figures illustrate trends which have assumed great importance in the 1970's—trends that require awareness, consideration and community cooperation.

FROM A TO Z WITH ADOLESCENT SEXUALITY



Benjamin Schlesinger

The adolescent is neither child nor adult. He is a complex between-ager presenting us with intricate and often perplexing problems. Adolescent sexuality is not something that we as nurses can ignore, rather it is something we must face daily, both at work and at home. What are our responsibilities to our adolescents?

ACTION especially community action. Talking, slogans, conferences and reports all serve their own purpose but it is time for communities to take positive action insofar as adolescent sexuality is concerned.

BASIC ISSUES underlie the complex topic of adolescent sexuality. We cannot discuss or examine adolescent sexuality in a community without examining these factors. They include the political system, religious beliefs, culture and economy. A thoughtful examination of these basic issues will clarify our view of the sexual politics in our communities.

CONTROL What type of control should our communities have over sexual behavior? There exists in the world today a wide range of methods of control: from China where there is political, almost total control over the sexuality of adolescents, to the American laissez-faire attitude. "Do what you want, when you want, just don't bother me."

DOUBLE STANDARD This double standard makes adolescent women responsible for their actions while adolescent men are not — after all, boys will be boys. If our communities let this double standard continue then, quite frankly, we're not going to get anywhere. Instead of the time-worn double standard, we must establish a new standard which should be "equality for all human beings."

EDUCATION and in this context, I mean primarily sex education. I do not believe we have really considered many of the practical questions that surround the introduction of sex education into our communities. How should we start? Who should teach sex education? What approaches are best for each individual community? What information should we transmit, to whom? One of the most important things we have to remember is that each community has different values — different norms. A textbook or training material appropriate for one community may be wholly inappropriate for another.

FATHER Let's not leave him out of any discussion that concerns adolescent fertility. We traditionally ignore the father — discussions of his conduct are usually negative and often jocular. I consider adolescent fertility a family affair; babies born out of wedlock are born to two people, a mother and a father. Social work tends to leave out that essential third party. The shadow of this family is the unmarried father. It is time we included him; not in a punitive way but in a positive vein. We must remember he too has feelings and emotions, he too is an adolescent. The experience of fatherhood has, without a doubt, affected him and he may need help.

GROWNUPS or adults. I see grownups as models, not as judges; as examples, not as hypocrites. The old saying, "Do as I say, not as I do" seems to express the situation prevalent in many parts of the world. We should not be surprised that through their actions youngsters reply, "You do not act as you advise, why should I act as you tell me to?" It is time that we, as adults who represent the community, look within ourselves and examine what kind of examples we are setting.

HEALTH No one would argue the fact that we need good physical and mental health services but sometimes I feel we're so busy building clinics and hospitals that we neglect some of the novel approaches to health care. There is, for example, a whole paramedical approach to working with adolescents that has yet to be explored in many places. Let's face it, there are not enough trained doctors in the world to do all of the work that is necessary — we can't leave it all up to them. Nor do doctors want to provide some of the health and quasi-medical services which adolescents need; our communities must be ready to provide them.

INVOLVEMENT especially community involvement with adolescents. Professionals, volunteers, institutions, doctors, teachers, social workers, religious groups, social groups and cultural groups should integrate their work rather than follow a piecemeal approach to health care. Right now, one person is interested in the adolescent's head, another is interested in his mouth and his diet. There is no one person who sits down and talks with a young man or young woman as a complete person — a whole being.

JUSTICE Not punitive, but therapeutic justice. Many laws, regulations of social agencies and community policies are punitive and very often they are entirely unenforceable. We need to reexamine them considering both community values and justice for the affected adolescent.

KINDNESS It is time for us to begin treating all adolescents with kindness. They are worthwhile human beings who need love. We should stop rejecting them just because their behavior sometimes clashes with our 'ideal.' They need understanding, not accusations; they need warmth, not coldness; they need to be included, not isolated from our communities.

LIMITS Are there no limits to the acceptable sexual behavior of adolescents within a community? We have to reintroduce one small word into our communal vocabularies; that word is NO. Sometimes we, as adults in the community, appear to want to leave all decisions about sex up to adolescents themselves. Our attitude says, "do as you choose," but there are times when we should say "NO." Most of us who have worked with children know that even the most independent adolescent does want some kind of limits set on his behavior. In many places we are moving towards a situation where adolescents do not know what the limits on their behavior are or if any limits exist at all.

MEDIA In spite of the fact that there are universal complaints concerning the misuse of television, radio and newspapers there are positive ways we could use the media for adolescent education. I'm not saying that we should produce ads proclaiming, "A pill a day keeps the babies away" or "Technicolor Condoms will save you from V.D." I am talking about a positive approach to fertility and sexuality using all of the knowledge we now have. One of the most effective, positive efforts we could make would be to educate, not only adolescents, but also their parents through our media.



NATIONAL GOALS Does our national government support communities who are trying to help adolescents or are we working in a vacuum? For example, a government may announce a sex education policy, but if there is no implementation procedure included with this policy then what is its use? What is the use of a beautiful document 220 pages long if it is not implemented by a national program. A document alone cannot stop my teenager, or yours, from getting pregnant.

OPENNESS We must open our minds to new ideas. We need not blindly accept every new idea, but let's examine them each for their own value. For example, I have found that I, who live in an "industrialized country" can learn a lot from the work being done with adolescents in the so-called "non-industrialized countries." There is much to learn from other countries and from the efforts of other communities in our own country

PARENTS We must get parents involved in our work with adolescents. This is absolutely essential but how should we go about doing this? What's the purpose of getting them involved? We need to help parents for their own sake, as well as for the sake of their adolescent children. Adolescent sexuality and adolescent pregnancy (even the prospect of it) is a major source of anxiety, depression, frustration and general social and psychological maladjustment for parents Often they need help as much as (or more than) their own teen-age child.

QUALITY OF LIFE What is the "quality of life" in our communities? Is there respect for human beings? Do people care for each other? Is the individual adolescent considered and respected as a human being? Is there affection and love?

RESEARCH Certainly no one would deny that research is a vital part of our health care system. There are many areas we should study that deal with adolescent sexuality. Let's look at the different adolescents in our communities. What makes them different? What are their individual and collective beliefs? What do they think about the quality of life in their community? What do they believe the quality of life should be? What are the criteria for their decisions?

We have to remember that research should not be conducted for the sake of research alone. Our goal must be to help communities fulfill their responsibilities to their adolescent citizens.

SERVICES It is possible for us to overservice a community. Opening service areas is fairly easy, the problem is closing down once there are vested interests opposing any change. As a result, we now have many service units which overlap and duplicate each other. Yes, we do need services, but let's examine the type, our needs and the costs.

TRUTH Can we have a true dialogue between adults and adolescents without lies, sham and hypocrisy? What is the "truth" in human sexuality?

UNDERLYING CAUSES OF PREGNANCY This can include boredom, poverty, unemployment, a difficult home life, misinformation about sexuality and the effects of the community's morality on the lives of its adolescents.

VALUES Whose values? Should I impose my generation's values on the adolescent? What values do adolescents have? It's all very nice to talk about throwing out old values, but what worries me is that we have no substitute new values. It's almost as if we propose to throw old values in the garbage can and then throw out the garbage can as well. Suddenly, we have no place to put the garbage.

It's too easy to reject this or that basic community value without substituting anything in its place. We cannot live in a valueless society. Yes, adolescents are proposing a few warmed-over old values — what they call new values are really nothing more than old values with a new accent. We now have to consider at the community level, whether we (or the adolescents themselves, when they become older) would want these "new values" to be a permanent part of our community culture. Sexual values do not exist in a vacuum, they must be consistent with other moral, religious, psychological and social values.

WOMEN and in this case, especially adolescent women. It's time we began to recognize their rights; their sexual rights and their expectations. We must recognize that they have within them, the entire spectrum of adult needs, that they want to, and must be encouraged to participate with us as equals.

X-PERIMENTAL We need experimental programs. We need innovative programs that do not cost a lot of money but which are imaginative. There are some very beautiful program ideas that should be tried. We could, for example, utilize the arts, theatre, literature — the whole creative realm is open to us. Outreach work is another important area for experimentation. We have done a little outreach work here and there, but not nearly enough.

Our global society might honor a country for the construction of a special building for adolescents and adolescent research but this project may accomplish less than small experimental programs which are completed without fanfare, without trumpets. We do not have to build monuments for the youngsters which they do not need. We have to ask ourselves if the real goal behind the construction of these monuments is the improvement of the quality of life for our adolescents or our picture in the newspaper and headlines in the world press.

YOUTH Do we want to dominate our adolescents? Do we want to work against them, for them, or with them? Obviously working with them can be our only fruitful alternative. It is very likely that this is the first time in history where adults and adolescents have had the opportunity to work together as two generations, rather than continuing the intergenerational conflicts of the past. Both generations should seek cooperation, not authoritarianism; dialogue, not monologue; self-help, not external aid; and understanding, not deaf ears and unresponsiveness.

ZIP is North American slang suggesting zest, a high morale and readiness. We must become front-line soliders in our communities in the fight to liberate adolescents and this fight includes their sexual liberation. It takes great energy, fortitude and courage to take this stand. Right now there are a few pioneers who are fighting an almost lone battle on the national level. We need more people and we need this kind of energy and spirit at the community level.

When the words 'sex', 'adolescence' and 'fertility' are mentioned together in local discussion, there should be leaders who will stand up and speak their mind. It is very difficult to stand on a podium and shout aloud to your neighbors, "We need change." Such people are often accused of all kinds of subtle and not-so-subtle motives, nevertheless this is the kind of involvement and community action that we need and we must work towards it.



Benjamin Schlesinger *(B.A., M.S.W., PhD.) presented his paper "The Pregnant Alphabet" during the first Inter-Hemispheric Conference on adolescent fertility held in Virginia in the Fall of 1976. He was Canada's only representative at the conference where 39 nations met to discuss the increasing phenomenon of adolescent fertility.*

At present, Schlesinger is a professor in the Faculty of Social Work at the University of Toronto. He is the author of many books and articles concerning family planning, family life and sexuality.

In many ways, the nursing process is 'common sense'. It incorporates an approach that most of us use every day when we try to solve the problems we face. But each of us, from time to time, is guilty of sloppy thinking. We make assumptions about the problems we *think* a patient has; we think we know the solutions but never stop to evaluate their effectiveness; we fall into routine patterns of behavior — the old familiar 'rut.' Individualized nursing care, however, demands more than good intentions. It takes 'common sense' to look at a patient's needs and problems in an organized and perceptive way and to use the time we have with a patient, no matter how limited, in the best way possible.

the nursing process

a tool to individualized care



Lorraine Hagar

The use of the nursing process as a standard tool in all activities related to nursing has become a primary concern in our profession today. As a method that uses assessment, planning, implementation and evaluation as its formula, the nursing process is flexible and adaptable, applicable in any setting. It provides a deliberate, systematic and organized approach to nursing practice that accomplishes the main purposes of nursing — to promote wellness, to contribute to the quality of life and to maximize all resources.[1]

The nursing process requires the development of a therapeutic relationship between ourselves and our patients. We are past the day when nurses work with only one part of the patient — the part that is sick. Now we are challenged to utilize all our knowledge to assess the patient's strengths as well as his weaknesses so that he can share in the assessment, planning and evaluation of his care. Familiarity with theories and disease entities is no longer enough. We need to know our patients as individuals. For example, to know that Mr. Smith in Room 401 has hypertension is to know only a small part of what is happening to Mr. Smith. If we plan our nursing care solely on that "classification", we will do a poor job of meeting Mr. Smith's needs. The nursing process provides a framework — a tool of the trade — that we can use to find out more about Mr. Smith's needs in a systematic rather than a haphazard way.

It is the relationship we develop with our patients — a relationship that allows him and his family to take part in the nursing process, (that is, the assessment of unmet needs or problems, planning nursing activities to solve these problems, implementing the actions and then evaluating whether or not the actions did indeed meet these needs) — that constitutes the basis for our practice. As nurse educator and author Madeleine Leininger has said, "Nurses help people through a professional relationship that is learned. It is the use of the therapeutic relationship with patients that constitutes the heart of nursing practice and determines what is done to the patient and how it is done."[2]

In addition to information concerning the patient's personal history, capabilities and

limitations, knowledge of current and traditional theories from various disciplines can help to provide a working basis for the nursing process. A basic knowledge of man/environment interactions in various cultural settings may be an asset in assisting the individual in the immediate situation. The nurse must make full use of her knowledge of physiology, pathology, psychology, hospital and community facilities, family interaction and support, as well as her own intuition. Use of her knowledge base and constant re-evaluation will help to develop the nursing process into a personalized device, tempered by personal experience as well as formal learning. The nurse's efforts are aimed at helping the patient cope with his environment and society to their mutual benefit. It is often a tall order.

■ Brian — a case study

□ *Assessment*

"The assessment phase begins with the nursing history and ends with a nursing diagnosis. The purpose of this phase is to identify and obtain data about the client that will enable the nurse and/or client and his family to designate problems relating to wellness or illness. If problems exist, then the first step toward a solution is to identify them".[3]

Brian, a four-year-old victim of child abuse and maternal deprivation, was admitted to hospital for treatment of a fractured femur sustained when he fell off his tricycle. Six months prior to the accident, he had been taken away from his parents and placed in a foster home. Little personal history was taken at the time of admission and his foster parents, living in another town, were rarely able to visit.

To the nursing staff, Brian appeared to be physically as well as mentally immature for his age. He did not speak intelligibly and his level of development was that of a one-or two-year old. Brian was originally diagnosed as an autistic child. Later it was recognized that maternal deprivation was the cause of his behavior.



Brian was immobilized in a hip spica cast and restrained on his stomach in his crib. He reacted to the pain in his leg, to immobilization and to the strange environment by crying, violently kicking his free leg and tearing the bed sheets and toys. When someone attempted to make contact with him, he would either withdraw or lash out. He mistrusted everyone who approached him.

In assessing Brian's needs, the threats to his wellness included not only his broken leg but all the ramifications that this injury caused in upsetting his physiological and psychological patterns of daily living. For example, he could not sit to eat and often vented his frustrations by throwing his food. Sometimes, he would refuse food altogether. If he was hungry enough, he would eat anything in sight. His dirty diaper proved to be no exception. Elimination was a problem — any gains made in toilet training had been lost. A case of diarrhea made matters worse.

Brian's activity was largely curtailed by the cast and restraints. Rest was difficult because of his pain and agitation. These difficulties were compounded by an unfamiliar environment, and his great reluctance or inability to trust those trying to help him.

Generally, Brian dealt with his situation by aggression — by throwing or demolishing toys, food, bedding and attempting (sometimes successfully) to bite nurses. When very angry, Brian would destroy things with his teeth. When moderately upset, he would seem to find comfort in sucking on a diaper. It was interesting to note that in a calm state after Brian became used to me, he would examine and manipulate objects but made no attempt to put them in his mouth. He would sometimes even give the object back to me — a developmental task described by Erickson as "holding on" and "letting go."[4]

In this, he showed signs of having superseded Freud's oral gratification stage. He also demonstrated his ability to make choices, whether to let me have the object or not. Often, he changed his mind and decided

to keep it himself.

But when Brian actually tried to put his fingers in my mouth, I decided that he trusted me more than I trusted him. I didn't dare let my hand go near those teeth of his.

In working with Brian, I felt that the establishment of a trusting relationship was the top priority. Without trust, all care was inflicted on Brian by force and he, in turn, used up all his energy in resisting it. Any effort to restrain him, even to hold his wrist to take his pulse, was violently resisted. The greater the force used to restrain him, the greater were his efforts to resist. For example, he proved this 'heroically' when it took an orderly and two hefty nurses to hold Brian still for an X ray of his leg (already immobilized in the cast).

☐ ***Planning and giving care***

During the assessment, the unmet needs of the client have been identified. The purposes of the planning phase, the second step in the nursing process are:

1. to assign priority to the problems diagnosed

2. to differentiate among those problems that can be solved by the nurse, the health team and the client/family

3. to designate specific actions and their goals

4. to communicate the plan to others by writing it down in a nursing care plan.[5] *The third step in the process is the implementation of the plan.*

Brian's priorities differed radically from those of the health team in that he often did not want anyone to touch or come near him. When the goals of the patient and nurse are at odds, problems are compounded.

The abused child has an innate mistrust of those around him. In giving nursing care to Brian, I found that his mistrust of me could be overcome but that it reappeared with each contact. In establishing a trusting relationship with him, I had to follow a particular pattern of behavior each time. I did this by staying with him and letting him familiarize himself with me, by touching and speaking to him gently. I would let him handle the diaper I was going to put on him, put his fingers in the skin cream



Lorraine Hagar *of Englehart, Ontario is a third year student in the Faculty of Nursing, University of Toronto. She wrote "The nursing process: a tool to individualized care" as an integrative paper assignment during her second year. Her main areas of interest in nursing lie in the fields of pediatrics and community health, both of which she hopes to pursue in a nursing career in Ontario's northern communities.*

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and touch anything used in his care. The music from a windup toy radio helped to soothe him and I would hold his hand on the knob to wind it up. Once a measure of trust had been developed, he would allow me to wash him and do cast care without too much fuss.

The importance of Brian's need to manipulate, explore and exert some control over his environment is emphasized by a review of the developmental tasks of the toddler stage. Although Brian was far behind developmentally, his capabilities seemed to vary with the degree of agitation he experienced. Using this rationale to plan activities and an environment conductive to successful achievement of these developmental tasks would, I hoped, prevent Brian from regressing to a great extent while hospitalized, and also provide him with sensory stimulation.

Brian became much more approachable and settled when freed from his restraints and placed on blankets on the floor. He soon learned to log roll over the cast and pull himself around to reach a desired toy. If the room was quiet, Brian could be encouraged to become interested in toys, instead of just throwing them around to release his frustration. It also became apparent that Brian could feed himself with a spoon and drink out of a cup. His ability to focus his attention and perform tasks varied with his level of anxiety.

Brian's cooperation could only be enlisted by a very slow, gentle approach, preferably by a familiar person. If he was given no opportunity to adjust to a new environment, procedure, or person, the result was a hysterical, kicking, screaming little monster, lashing out tooth and nail.

However, after he had tested out people and his environment, assuring himself that neither would harm him, his destructive tendencies disappeared (for a time) and he showed evidence of more advanced motor and social development such as feeding himself with a spoon, parallel play, interest in my book, pen, watch. This first step towards developing trust appeared to be the key to helping Brian achieve a sense of security and a balanced state from which he could progress.

□ *Evaluation*

"Evaluation is always in terms of how the client is expected to respond to the planned action ...(It) is the natural intellectual activity completing the process phases because it indicates the degree to which the nursing diagnosis and nursing actions have been correct."[6]

My primary purpose during the short time I spent with Brian was to establish a therapeutic relationship which in itself would meet his basic need for someone to trust. Brian's mistrust of everyone appeared to stem from the damaging effect of his previous interactions with his parents as a victim of child abuse. In nursing Brian, I tried to concentrate on ways of caring for and assisting him rather than to accomplish or inflict set procedures such as taking vital signs, feeding, washing, giving skin care, and doing cast care. My aim was to involve him in his care, and find acceptable ways to acquaint him with the different procedures so that he would not find them so frightening.

Brian's problems appeared to be interrelated. In attempting to stabilize his food and fluid intake, by providing a quiet atmosphere and freeing him from his restraints, I hoped that his elimination would become more regular so that "bed pan training" might be initiated in the future. If the discomforts of indigestion, loss of bowel control and emotional turmoil were diminished, regular periods of rest and sleep could promote his recovery and perhaps improve his behavior.

Although Brian did not fit into any one developmental level, appreciation of the uniqueness of his personality and the effect of stress on the individual prevented me from vainly trying to categorize him. He presented the sad picture of what can happen when basic needs are not met early in life, and critical developmental tasks are not successfully accomplished. Brian had to repeatedly test out people and his environment, to gain confidence in his own ability to trust, or to decide not to trust.

In my attempts to focus Brian's attention, to promote familiarity, to provide a quiet atmosphere, and to reduce the barrage of incomprehensible stimuli, I was able to see Brian's progress, or rather his reattainment of a previous level of development. Unfortunately, in controlling his environment, I did not prepare or reconcile him with the changing circumstances he would face again the next day, when he would be open to the approaches of many different and unfamiliar people. He was considered a problem by most of the nursing staff on the floor and care was often given in the most expedient fashion, not necessarily tailored to Brian's unique needs. It would have been beneficial if the same nurse could have arranged to care for him on a regular basis.

Although I cared for Brian for only two days, this proved long enough to utilize and carry out the elements of the nursing process. At times, the process seemed to be reduced to a modified trial and error method, but its effectiveness was measured by the change observed in Brian's behavior. He began to respond to verbal commands and his destructive tendencies and wild behavior gave way to explorative interest in his environment.

I presented the approach I had used in caring for Brian to the staff nurses I came in contact with and also made explanatory nursing notes. The staff did substitute mats for his crib to eliminate the need for restraints and provide Brian with more sensory stimulation and freedom to explore his room.

In spite of this, however, my plan failed to maintain the element of continuity and pattern necessary to fulfill the purposes of care. It was reported that by the time of discharge, he had regressed further. The regular staff simply did not have the time to devote to Brian to make my plan a success.

Even so, this does not mean that the nursing process is bound to fail on a busy hospital floor. The key to the nursing process is continuity and consistency. Interaction that has proven to be effective needs to be continued and reevaluated by all nurses in contact with the patient. It takes a reorganization of thinking — to look at needs in an orderly, logical manner and to think things through. "What is this person's need? What actions can I take to help him meet these needs? Were my actions effective?"

"Doctors, nurses, health visitors, social workers, speech therapists, radiographers, dieticians and teachers are educating others constantly about health both directly and indirectly. It is not so much a matter of seeking special opportunities as of making the right use of existing contacts with pupils, clients and patients. In education for health we are learning together with other people, rather than instructing the ignorant." (Michael Wilson)

SECONDARY SCHOOL NURSING

A CHANGING FOCUS



May Brown



In Eastern Ontario, where I work as a school nurse, secondary school health service has always been the responsibility of the provincial Department of Health. Teams of nurses have provided services such as immunization, counseling, vision and hearing tests, health teaching and consultant services.

The main focus of the school health service in the past has been on prevention. Mass screening devices were implemented to reach large numbers. By throwing out a large net we hoped to "catch" health problems. We taught the healthy how to stay well, and we counseled the ill as we came across them.

Attempts were also made to counsel all grade 10 students in secondary schools, as this age group is approaching adulthood and many adolescent physical and emotional changes are taking place.

The screening method is still an acceptable standard where school health services are being introduced to an area; for example, trained teams of specialists and technicians can, in only one to two days, complete vision and hearing tests on an entire school population. However, my own experience as a school nurse led me to question whether the screening method was the best way to cope with the health problems of high school students. Health is a large word; it means more than giving polio shots or a clean bill of health on a chest X-ray, important as these may be.

Three years ago, when I was asked to take responsibility for the health of a local high school, I decided to try a more personal approach with the students and a more cooperative and collegial approach with teachers and other school staff.

The local high school I was assigned to had a population of 80-90 teachers and about 1400 students. The school health program at that time included tuberculin testing for grade 9 students, "boosters" for diptheria, polio and tetanus in grade 10, *and counseling and vision testing for all grade 10 pupils. Individual health care problems were referred to us by the teachers. Added to this was the need to keep an eye on all those students whose health problems had been discovered while in elementary schools. I worked at the school three half days weekly, Monday, Wednesday and Friday mornings. I saw students by appointment whenever possible, and planned each interview to last ten minutes.

My interview questions were designed to elicit information about a student's daily routine, his attitudes and his health. I checked nutrition styles, bedtime habits, studying patterns and work performance in school, that is, the student's last class average.

I usually tried to find out what the student's expectations were of himself. I was surprised to find that when a student's school performance was below par, he was usually well aware of the fact.

During the interview I enquired about tensions at home, part-time jobs, and students' career aspirations. Students with problems stemming from these were sent directly to the guidance counselors for further help.

I found this program most effective in my first year. It gave me a picture of health patterns and a good background of knowledge and experience. However, this approach also had its drawbacks.

The workload became too heavy and took up too much of my own and the students' time. I found that a 10-minute health counseling session cost each student at least half an hour out of class. I worked with one grade 10 class after another, seeing between seven and eight pupils on an average morning. At the end of each class group, I conducted a guidance-health conference with the counselor assigned to that particular class. Healthy, above-average students were given the same attention as those needing care and advice. I felt this was a waste of counselor-teacher nursing hours. After all, parents still have the final responsibility for their teenage children — why was I spending valuable time with obviously healthy students? A further difficulty was how to alert teachers to the health problems in their classrooms, so that they could refer them to us.

But by far the most serious problem, in my opinion, was one badly neglected area of health supervision — the multi-problem slow learners in the occupational classes.

This school had at least three classes each in grades 9 to 11, for students who would not finish high school but would "graduate" straight to the working force. An average class carried 15 to 20 students from various social levels — the majority from lower-income families.

Lifestyles in this group were less restrictive and more relaxed. Less emphasis was placed on class performance or career goals. Bedtime habits were erratic and students often had part-time jobs; they were more assertive, and matured earlier.

Their casual attitudes and "don't give a damn" air were a nightmare for their teachers. Many were in trouble with the law, and their names came up constantly across the counseling tables.

In my first year, I saw these students only towards the end of the term, too late to do effective health teaching with proper follow-up.

Occupational students were isolated from the greater student body. They had their own teachers and counselors separate from the regular student population in the four- and five-year plans.

The students in this group presented a real health problem but they were lost in an upper middle class school, and were virtually ignored by the regular staff. Their teachers encountered constant frustration, limited parental ability and interest, as I did myself. One parent, who was advised to get a medical assessment for her daughter, told me that what the child needed was discipline, not a medical referral!

I decided to start my second term at the school with early emphasis on these occupational students.

*"Boosters" — diphtheria, polio and tetanus for students under 16 years, tetanus and polio for those 16 years.

In September, I interviewed counselors, teachers and department heads and altered my program to give priority to the occupational department. I organized classroom conferences with teachers, so that I could gather information about students before assessing them individually. My goal was to concentrate on interviewing and counseling grade 10 occupational classes; I would take the other students only when they were referred to me.

I found the pupils very interesting. After their initial shyness and distrust had passed they were often eager to pour out their problems. They were good listeners as well. I attempted to reach them through a common sense approach and adapted my standards to their individual interests and abilities. In this way we usually came to an agreement on acceptable concepts of good health.

Early drinking, smoking and some drug use surfaced. Many of these students had been in and out of the courts, and had a "street" knowledge that was superior to that of the average student's.

Many of their problems were beyond the scope of the health program but a good, supportive psychology team had just been added to our resources. We now had monthly meetings with a psychologist and a social worker, both of whom used private and group therapy sessions to counsel and re-direct students' lifestyles. This team has now worked together effectively for three years. The inclusion of professional help from a local hospital-based psychiatric unit, has helped us develop into a cohesive community service.

The result of these changes in my approach to school health problems was that my work began to extend more and more into the community. Interviews were longer and more searching. Often I followed the student-nurse conference with a phone call. I had soon discovered that "notes" home were virtually ignored, but no one could deny a properly recorded telephone message. Often I was able to get parental backing on health habits. Sometimes of course, I was not.

Typical examples of my "cases" are students "A" and "B."

Student "A", a young grade 9 student, was referred to me by his teacher following complaints of blurred vision. On tests, he performed at a normal 20/20 level, but admitted during the interviews that his home life was erratic, his nutrition was poor, he smoked five - six cigarettes daily, and he stayed up late at night. He liked sports, but was unable to compete well on teams because of wheezing and shortness of breath.

I reviewed his nutritional requirements, worked out a menu plan and advised him to cut the cigarettes out to see if he perked up. On review two weeks later, this student had made an effort to improve his meals and lifestyle, but still maintained irregular hours on weekends. We felt parental supervision was lacking here. After a conference with the Occupations Department Head, it was decided to visit the parents and request stricter home supervision with attention to teenage drinking at home, all-night parties (also in the home), and early dating.

Extensive family therapy may have to be initiated if this boy is to continue in the school system.

Student "B" arrived at my office looking pale and complaining of severe headaches. His health record showed a history of vague stomach complaints for which a physical examination by the family doctor had produced no diagnosis.

After a home visit with his parents, and following several interviews with the boy, I felt his main problem was deep anxiety for his academic program. Under parental pressure to produce academically, he had been assigned a program above his achievement level. The guidance counselor called in his parents, and advised them that "B" required a reduced workload at a more basic level. I referred him again to the family doctor, who agreed to send him for psychiatric counseling if the headaches continued. Two weeks later, he returned to the health office. He was more relaxed and interested in school, but still showed physical stress signs — poor nutrition, heavy smoking, tiredness, and so on.

The Guidance Department is aware of the direction of my concern and referral to the Mental Health Clinic has not been ruled out.

Another area of my new "look" involved the recently organized Attendance Department within the school system. The board hired social workers to counsel "A.W.O.L." cases, and others with chronic absenteeism problems, which were often covered up by the family through such means as "doctored" notes. Chronically "sick" malingerers were often found within this group.

By inviting cooperation between the Attendance Department and the Health Service, I was able to teach and counsel very effectively in this area. Many minor ailments showed up: headaches, nerves, stomach aches, and so on. In-depth interviews uncovered deeper emotional problems or unstable home conditions. I used a two to three week trial period for improvement, and if this was ineffective we called in our counseling team and outside support. Table 1 shows how my workload changed as I established contact with the other helping units.

Last year, the school underwent major renovations and we were forced to slow down. This proved a good time to make changes in our program without creating uneasiness.

We no longer use extensive screening and we no longer have line-ups outside the health room door. Referrals are by request and appointment only; most are multi-problem cases, attendance delinquents, and students referred from the occupational and guidance departments.

All the department heads are most cooperative. Problem cases arrive more quickly than in the past and are dealt with more



Table 1
Three year program for change

Time	Activities
1973-74 3 Mornings Weekly	Nurse-guidance conferences — 13 Grade 10 classes. Interviews — Grade 10 students. Referrals — Grade 9, only major health problems. (1st year with Psychology Team).
1974-75 2 Mornings Weekly	Conferences with vice-principal re: attendance problems. Conferences with guidance department re: students with health problems. Assessment of all Grade 10 occupational students. (2nd year with Psychology Team).
1975-76 2 Mornings Weekly	New attendance department, referrals and follow-up Individual conferences with guidance department. Occupational students on referral. (3rd year with Psychology Team).



efficiently. We have monthly conferences which last about one to two hours. More and more I am "out" of the health room and "into" the classroom, particularly, in the occupational department and I have reduced my school time to two half days weekly.

By offering support to the teaching programs and with the aid of new pamphlets and posters distributed by the health unit, we can carry out health teaching in a group setting. Topics such as nutrition, good grooming, and sex education are discussed openly in the classroom, with tact. Sex education in secondary schools is still carried out at the discretion of individual school boards, but public health nurses are gradually breaking down public reservations. If we receive parental support for our teaching methods on this subject, I hope the end result will be better informed teenagers.

The changes I have built into my work as a school health nurse are more goal-oriented, and therefore make the work more exciting and interesting .

I believe the trend away from mass screening in the secondary schools will allow more time to deal with individuals, and their health and related emotional problems. The trend towards prevention in a classroom setting also permits the public health nurse to become a valuable team member on a consultative basis, available to students, teachers, psychologists and counselors alike.

May Brown, *who wrote "Secondary School Nursing: a changing focus" is a member of the staff of the Eastern Ontario Health Unit working out of its Cornwall office. She graduated from Hotel Dieu Hospital in Cornwall and received her certificate in Public Health Nursing from the University of Western Ontario. Before returning to Cornwall, she was a member of the staff of the Windsor and Essex Health Unit in southern Ontario.*

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A CANADIAN GRAD GOES TO THE STATES





Last Spring, when the job market for nurses in Canada tightened up, hundreds of graduates from schools of nursing in this country headed south of the border to find work. Author Katherine Zin, valedictorian of her class at Seneca College in Toronto, was one of them. She found a job in Florida — a state which is always short of nurses since it has only one school of nursing and a total of 22 hospitals. Unlike many of her contemporaries, many of whom headed home after only a few months, Katherine is still working in the United States. Sometimes, though, she thinks about returning to Canada. This is her story of what it's like to begin your nursing career 1,500 miles from home and why she's coming back one day.

Katherine Zin

The answers all came back the same. "We regret to inform you that we have no position to offer you at the present time. However, we will keep your application on file for future consideration ..."

The spring of 1976 was an exciting but frustrating time for me and for other nursing graduates across Canada. Our education in a chosen field had almost been completed, but the job market was bleak at best. Although I very much wanted to stay in Ontario or go to western Canada, there were few jobs available. There seemed to be only one alternative.

The United States provided a "land of opportunity" as far as jobs were concerned. Unlike Canada, the U.S. had, and continues to have, a shortage of nurses. The job market and professional opportunities were wide open and I was only one Canadian nurse who took advantage of the situation.

Florida was my choice because it not only promised a job, but also the fringe benefits of sun and surf. And so, after settling in an apartment on the ocean, I began my career as a registered nurse.

I found that nursing in Canada and the United States has few basic differences. Many of the adjustments that I had to make as a new graduate starting my first job would probably have been the same if I had begun work in Canada. I became the subject of something our teachers had warned us about — reality shock.

The shortage of nurses in the United States had benefits because it opened up opportunities for Canadian graduates. But it also meant difficulties, because everyone had to deal with the shortage. I had to adjust quickly to the realities of short staffing.

Orientations always promise ample time to prepare a nurse to become an active and productive member of the health team. Reality however, often forces a new grad to be that productive member before she is ready. From the protective and safe environment of the teacher-student relationship, I suddenly found myself in charge of 38 patients on an orthopedic ward at night.

I soon transferred to the intensive and coronary care unit. During my training, I found that specialty care areas often had to be restricted to a day-long period of observation. Certainly I found the opportunity to work in ICU exciting, challenging and rewarding, but adjusting to the pace had its ups and downs.

It became necessary for me to rethink and redefine my attitudes about health care. Those "respiratory patient" disputes, so well-publicized through the media, became real situations that I had to deal with daily. I was forced to develop my own ideas about "keeping patients alive" by mechanical means. I found it very trying at times, especially because it was coupled with the ever-present threat of legal implications for every nursing action. But helpful co-workers and understanding supervisors helped me to adjust to the new demands I faced. My fulfillment as a nurse provided me with the reward that kept me going.

These were some of the problems that faced Katherine Zin, R.N. But Kathy the person had problems to face too. I was 1500 miles away from home in a foreign country. I can't say it was always easy but I had a lot going for me.

I had lived away from my home in Windsor, Ontario for two years during my nursing training in Toronto. I had also moved to a country whose culture is very similar to that of Canada. I've found Americans, especially here in the south, extremely friendly and helpful. Everyday life is very much the same — although the pace here is so much slower than in Toronto.

The biggest difference I guess, is that it's just not Canada. I find myself living with a nagging desire to be back in Canada no matter how well things are going here. Homesickness is always with me, in varying degrees. Perhaps this is just something that everyone who leaves home has to deal with.

I am still here in Florida, and enjoying it very much. But to be honest, if a job were offered to me in Canada, I would find it difficult to turn down. Here, I am growing in experience and knowledge. I hope that someday in the near future I will be able to return to Canada and contribute to our own health care system all I have learned here in the States. Better still, I hope that soon our Canadian graduates, who have so much to offer, will have the opportunity to care for patients in Canada from their first day as registered nurses.

Katherine Zin *(R.N.) graduated from Seneca College School of Nursing in Toronto in 1976. She is currently employed as an ICU-CCU staff nurse and relief night charge nurse at Hollywood Medical Center in Hollywood, Florida. Kathy hopes to continue her education in nursing and plans to move into the area of teaching in the future.*

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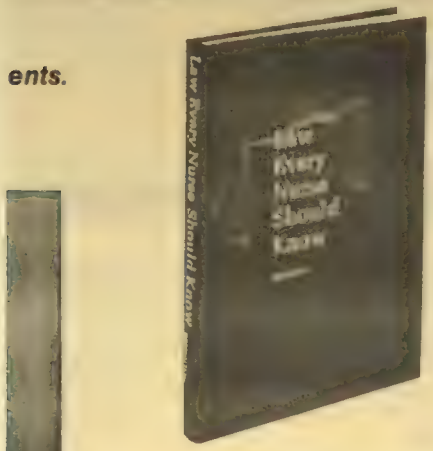
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Research

- **Education**

Internal Evaluation of an Experimental Dacum Curriculum in a Diploma School of Nursing. Boston, 1976. Dissertation (Ph.D. in Education) Boston University by *Jane Clare Haliburton.*

An internal evaluation study was done in one hospital school of nursing to determine if the Dacum system approach could be successful in a nursing education program. The criteria used were the pass rate on the R.N. exams, and the philosophy and objectives of the school. (The Stufflebeam C.I.P.P. evaluation model was used for the study).

The Dacum system approach includes planning, implementation and student evaluation. It is based on the development of a Dacum Chart which is a profile of the job as defined by employers, supervisors and people skilled on the job. The skills are expressed in behavioral terms which are meaningful to people on the job. The chart is given to the faculty and forms the basis of the curriculum.

Sources of data for the study included minutes of meetings, audiovisual tapes, feedback from teachers, students, head nurses, and employers as well as detailed records kept during the experiment. Evaluation of the learning environment was done first, from which evaluation criteria were developed for minimum standards expected of the student prior to graduation. Two interim evaluations were carried out during the program and modifications were made when needed. Rationale for the modifications were recorded.

The program was run as close to the Dacum proposals as possible for the first two years. Students were given freedom to learn in an environment where all content had been integrated into learning packets or modules. Evaluation results showed that integration had been carried too far and some students were confused, and could not recognize the core information which could be transferred to many situations. Students identified a need for some deadlines and guidelines, and frequently requested lectures.

In the third year of the experimental period, the material was presented to the first year students with assignment guidelines that forced the student to integrate the content. These students were able to function as independent learners in their second year.

The school provincial standing in the R.N. exams jumped four to seven places; the students passed with high marks. Faculty and students expressed satisfaction with the process. The Dacum systems approach to curriculum planning, implementation, and evaluation proved to be successful in one school of nursing.



- **Continuing Education**

The Continuing Learning Activities of Graduates of Two Diploma Nursing Programs in Ontario. Guelph, Ontario, 1976. Thesis (M.Sc.), University of Guelph by *C. Marilyn Anderson.*

The purpose of this study was to determine the influence of nurses' pre-professional learning experiences on their participation in professional continuing learning. Relationships were also investigated between participation in professional continuing learning and selected biographical and employment characteristics, interest in nursing, satisfaction with pre-professional learning experiences and perception of competency.

The study sample consisted of 191 registered nurses who graduated from two diploma nursing programs in Ontario in 1973 and 1974. A mail questionnaire was used for the collection of data. Factor analysis of the pre-professional learning experiences and multiple regression analyses of independent and dependent variables were the statistical procedures used for testing the major hypothesis.

The principal finding was that no single pre-professional learning experience, or identifiable types of learning experiences, had significantly predictive value for participation in continuing learning. Rather, a wide range of learning experiences in the pre-professional period appeared to contribute to a high rate of participation.

The observation has been made that in order to maintain competence nurses need to become increasingly self-directed in their continuing learning activities. The findings of this study imply that this goal may best be achieved by making available to the pre-professional and to the professional nurse, a variety of learning approaches and resources.

- **Renal Failure**

Knowledge Reported by Chronic Renal Failure Patients in Four Areas Related to Self-Care. Toronto, Ont., 1976. Thesis (M.Sc.N.), University of Toronto by *Susan Dawn Smith.*

The purpose of this study was to examine what selected knowledge related to self-care was reported by a group of patients with chronic renal failure on a hospital dialysis program. The ultimate purpose was to identify omissions and/or misinterpretations of knowledge related to self-care, in order to plan a suitable educational program for chronic renal failure patients.

Twenty-eight patients from three hospital dialysis programs were interviewed and questioned concerning their knowledge related to four areas of self-care, namely: condition, effects of condition, therapy, and effects of therapy.

Results indicated that, in terms of the definitions employed, subjects did not report knowledge in any area that would allow them to assume responsibility for self-care.

The findings in each area are as follows:

1. Knowledge Related to Condition.
The majority of subjects who experienced symptoms such as dyspnea, ankle edema and weight gain were able to associate them with overhydration, but could not state appropriate actions for prevention. The cause and prevention of hyperkalemia were better understood. In general, subjects with more than six months' experience on dialysis knew more about the irreversibility of the disease, its causal relationship to overhydration and hyperkalemia and the appropriate actions to alleviate the symptomatology.
2. Knowledge Related to Effects of Condition.
Only two-thirds of the sample seemed to recognize the dangers of infection. In general, those subjects with more than six months. experience on dialysis were more concerned about infection. The majority of all subjects expressed little concern about hemorrhage and failed to appreciate the importance of extra-renal complications.
3. Knowledge Related to Therapy.
Dietary and/or fluid restrictions were seen as part of therapy by only a very few subjects and only about one-quarter of the sample could correctly name or describe all their medications.
4. Knowledge Related to Effects of Therapy.
The majority of subjects were unaware of side-effects of their medications, and length of dialysis experience seemed to have no reinforcement value. Similarly, the habit of daily weight-taking declined with additional time on dialysis.

Since almost half the subjects were employed and/or maintaining a home, the study raises the question of how much better they would function with a broader knowledge base.

Recommendations included more accurate initial assessment of the patient's emotional and intellectual status, and the development of a formal teaching program emphasizing knowledge areas identified as unsound.

Books

Creative Teaching in Clinical Nursing, 3ed. by Jean E. Schweer and Kristine M. Gebbie, St. Louis, The C.V. Mosby Company, 1976.
Approximate price $8.35
Reviewed by Joyce Nevitt, Professor of Nursing, School of Nursing, Memorial University of Newfoundland.

The authors provide the key to this book in the preface, where they note that creativity cannot be taught, but that each teacher has a "potential for some degree of creativity ... The degree and kind are dependent upon the individual..."

Unit one places teaching clinical nursing in perspective. Development and trends are described in relation to the scientific and social changes which have influenced nursing education, and the discussion is supported by reference to numerous studies that have been done in the past decades. Throughout the book, definition of terms with emphasis on key words, avoids ambiguity.

The second unit discusses both the administrative responsibility for providing a climate within which teachers can be free to develop the "potential" for creativity, and the personal qualities of the effectively creative teacher.

The major part of the book is devoted to the application of principles and methods of teaching nursing. In their discussion of multimedia devices and methods, the authors focus on the person rather than on the equipment or method. Relative values of different methods of teaching are discussed against a clear understanding of the relationship between the stated philosophy of the school and of the objectives to be achieved.

The purposes and processes of evaluation are described in terms of meeting the goals of the evaluatee, whether of the student or of the teacher, rather than as a superimposed judgment based on the intuition of the evaluator. The assessment of the student's performance is viewed as a progressive process throughout the program, using a variety of tools, and showing how the creative teacher applies them in cooperation with the student. The evaluation of the teacher is based on criteria acceptable to both the evaluatee and evaluator.

Finally the teacher's roles and responsibilities to the profession and to the community, are seen as personal commitments which are vital to the development of creativity in the teaching of nursing.

Teachers who seek a "how-to-do-it" handbook will be disappointed, but the thoughtful reader will find stimulation, support, and encouragement. She will discover a means of self-evaluation by which to compare her own performance with the precepts and concepts presented in this well written, analytical, and thought-provoking book.

There is an impressive list of references at the close of each chapter, and a comprehensive index.

The essence of this book lies on the printed pages. For those to whom "eye appeal" has a psychological attraction, it is suggested that they take time to study the contents carefully before making a judgment, for in appearance, the book lacks the sharp focus that artistic printing styles can create.

Creative Teaching in Clinical Nursing should be in the hands of all teachers of nursing, all administrators and others who are involved in providing the teaching environment, and in evaluating teaching.

Behavioral Methods for Chronic Pain and Illness, by Wilbert Fordyce, The C.V. Mosby Company, St. Louis, 1976. Canadian Agent: Mosby, Toronto.
Approximate price $10.00
Reviewed by Christina Mikoski, B.Sc.N., Teaching Master, Nursing Program, Confederation College, Thunder Bay, Ontario.

A lengthy introduction serves to familiarize the reader quite well with what is to be expected from perusing the book. It examines chronic pain from a behavioral perspective, including the manifestations in the affected individual, the effect on significant contacts, and the proposed treatment modalities. Many of the attitudes and approaches developed in relation to chronic pain may be suitably adapted to other problems one encounters in chronic illness.

The book is divided into three main sections. The first one covers concepts of pain and psychogenic pain in behavioral terms. It also relates operant conditioning learning theories to the development of behaviors associated with pain.

Section Two, titled Evaluation, begins by establishing treatment goals through examining medical problems from a behavioral viewpoint. There is a fairly comprehensive chapter presenting a behavioral analysis guide which should help an interviewer establish the degree of operant pain, the presenting problems of the patient, and the significance of other persons. The short chapter on patient selection concluding this section examines the suitability of potential patients for operant-based management.

Section Three focuses on treatment methods which are designed to reduce pain or sick behavior, to increase exercise and activity level, and to modify factors which positively or negatively reinforce pain behaviors. Orientation of patient and family to the treatment process serves as an appropriate first chapter in this section. A useful chapter deals with patients who have medication problems and a medication deconditioning program involving use of a "pain cocktail" at regular intervals in steadily dimishing strengths.

There is an adequate bibliography and index in the book. Numerous graphs and diagrams are used to illustrate issues.

The book is well-written in a clear, easily understood format. It would serve as a useful reference in any nursing library and as a thought-provoking resource for any individual concerned with the problem of chronic pain.

Psychiatric Nursing in the Hospital and the Community 2nd ed. by Ann Wolbert Burgess and Aaron Lazare, 520 pages. Prentice-Hall Inc., Englewood Cliffs, N.J. 1976.
Approximate price $12.95
Reviewed by Mona McLeod, Professor, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

I liked the first edition of this book and find the second edition equally satisfying. Both editions have focused on people as human beings, and give recognition to our shared humanity in all its ramifications. Secondly the authors see emotional disturbances as a sign of people "suffering in their behaviors, in their thoughts, and especially in their feelings." "Mental illness represents the patient's attempt to cope with overwhelming experiences." The book, although directed to students and nurses engaged in psychiatric nursing, would be useful to all nurses engaged in working directly with people.

The format of the book is useful. For instance, the introductory chapters help individuals recognize and manage the feelings they experience when working with people who are emotionally disturbed, and again appeals to a wide range of concerns and worries commonly shared by students. The second chapter helps us to understand the anxieties and worries experienced by the patient in a psychiatric setting, anxieties added to the emotional problem for which he or she is seeking help. It seems important that these two areas of concern should be attended

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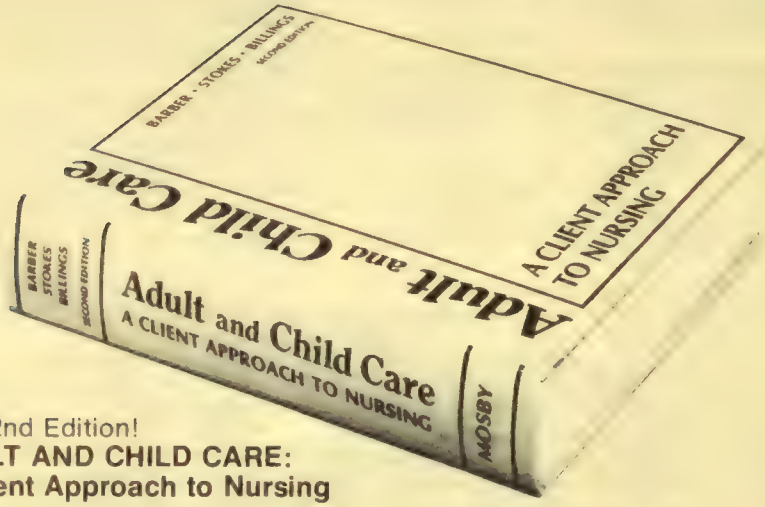
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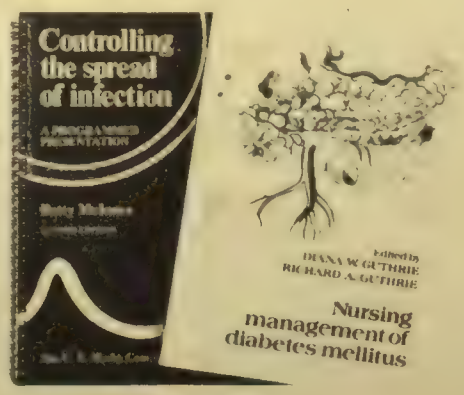
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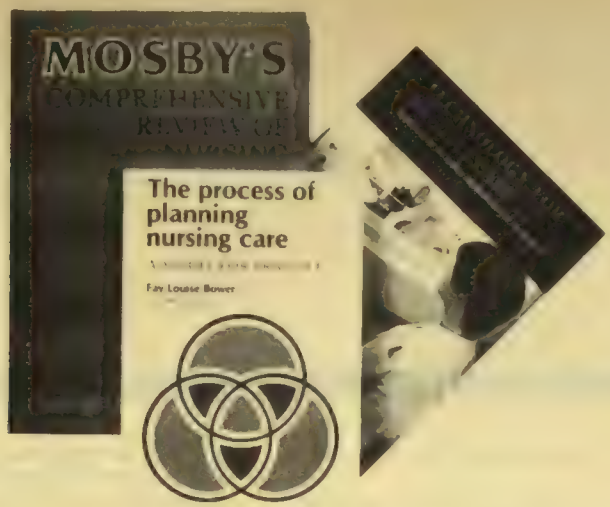
By **Janet Miller Barber, R.N., M.S.; Lillian Gatlin Stokes, R.N., M.S.;** and **Diane McGovern Billings, R.N., M.S.** March. 1977. 2nd edition. 1,036 pages plus FM I-XIV, 8″ × 10″, 738 illustrations. Price, $18.85.

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A New Book! **NURSING RESEARCH: A Learning Guide.** *By Natalie Pavlovich, R.N., Ph.D.* Covering every phase of the research process, this concise workbook helps students identify basic concepts and apply knowledge and skills. Eight well-organized chapters discuss: the problem; review of literature; hypothesis; research methodology; data collection, data analysis; conclusions and recommendations; and final reports. You'll appreciate the many helpful learning aids — including glossaries, selected readings, and discussion questions. January, 1978 Approx 320 pp **About $7.30.**



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A New Book! **REVIEW OF PSYCHIATRIC NURSING.** *By Donna Conant Aguilera, Ph.D., F.A.A.N.* This new guide offers a concise overview of the latest practices and concepts in mental health nursing. Easy-to-read discussions examine such topics as maladaptive behavior; psychiatric symptoms; management of psychiatric units, and crisis intervention. The author effectively bridges the gap between theory and clinical experience by allowing students to formulate the rationale for assessment January, 1977. 171 pp. **Price, $5.80.**

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to before proceeding with theory related to patient care.

Following the introduction, Part II considers the theoretical framework underlying practice. The conceptual models in patient care include biological, phychological, behavioral, and social models. The distinction made between models, in terms of philosophy, theory and goals is a useful one, offering guidance to the reader to explore further, as well as indicating implications for nursing practice. Psychodynamic concepts and personality development are reviewed and illustrated.

The review of theory in Part II provides a base for a consideration of the conceptual framework for nursing practice in Part III. The chapter headings include the Nursing Process, Techniques in the Therapeutic Process, Stalls in the Therapeutic Process, Interviewing Techniques and Therapeutic Interventions. Stalls in the Therapeutic Process is a particularly useful chapter in that it identifies common and specific situations in which planned therapy cannot proceed because the therapist becomes stuck in managing some of her/his own feelings.

The fourth part of the book is devoted to clinical syndromes. The syndromes are viewed as specific patterns of feelings, thoughts and behaviors. The emphasis is on the genuineness of human feeling, even though it may be considered pathological. Each chapter includes the nursing management of care.

The final section of the book is entitled The Community. These remaining chapters consider: social and psychological factors influencing human behavior; the concept of the customer approach to patienthood showing how the health seeker can help the provider; crisis theory and development; grief in terms of normal bereavement; the elderly in the community; alcoholism and drug abuse as community health problems.

The authors indicate the necessity for nurses to be socially conscious in their practice. The content of this final part comprehensively supports this view.

All in all this is a timely text.

Are You Driving Your Children to Drink? Coping with Teenage Alcohol and Drug Abuse by Donald A. Moses, M.D. and Robert E. Burger, 216 pages, Toronto, Van Mostrand Reinhold Company, 1975.
Approximate price $10.75
Reviewed by Colleen Stainton, Associate Professor, Faculty of Nursing, University of Calgary, Calgary, Alberta.

This book addresses one of the country's leading health problems — drug abuse and alcoholism in teenagers.

The authors, Dr. D.A. Moses, a psychiatrist, and his colleague, R. Burger, have developed a book that provides a framework for interviewing a teenager and/or his family when alcoholism or drug abuse is thought to be a problem, and for participating in decisions related to treatment.

The book is divided into four parts. Part I, entitled The Roots, describes the connection between teenage drug problems and the parent-child relationship. The absentee parent,



istant parent, inadequate parent, and psychotic arent are defined, with a psychoanalytical escription of the effects these parent behaviors ave on teenage offspring.

Part II, Storm Warnings, describes symptoms he teenager with a drug related problem will ave — depression, rebellion and dependency — nd his resort to drugs as an escape from these eelings and their effects on parent and peer elationships. Common misinterpretations of his ehavior resulting from society's sterotypes and xpectations are discussed and refuted. A clear escription of drugs commonly used concludes this ection.

Part III, Healing, describes the current therapies vailable: one to one psychotherapy, group therapy, nd concept therapy. Comparison of these ethods is made emphasizing that a key to success treating the teenager is the stimulation of the arents to change their behavior.

Part IV, The Public Problem, discusses the eed for society at large to familiarize itself with the real issue of teenage alcohol and drug abuse by giving up value-laden, punitive attitudes.

Schools, clergy, law enforcement offices and the parents must work cooperatively and knowledgeably in recognizing factors conducive to the development of this problem and in treating the problem when it does occur. This part concludes with a brief but thorough description of child-parent development and the importance of responsible and responsive love as the child moves from one stage to another.

An interesting bibliography is included.

This book would be an interesting reference book for any health team member working in schools, clinics or hospital units where teenagers are part of the clientele.

Management for Nurses: A multidisciplinary approach. Edited by Sandra Stone, Marie Streng Berger, Dorothy Elhart, Sharon Connel Fersich and Shelly Baney Jordan. The C.V. Mosby Company, St. Louis, 1976.
Approximate price $8.70.
Reviewed by Joan Peters, Director of Nursing Service, Charlottetown Hospital, Charlottetown, P.E.I.

This book is a combination of articles written by people in various disciplines and edited by a group of professors of nursing at the University of Oregon. It is divided into three distinct units with a study guide and bibliography as a follow up to each unit.

Unit one is concerned with structural factors and their influence on efficient organizational functioning.

When discussing philosophies, purposes and objectives and why we have them, it is clearly brought out that many times these are carefully prepared by people just because the job is to be done, that many times these philosophies and objectives are neither practical nor funtional. Many times "how" they are written and "what" they should contain is more important than "why" they were written and what one does with them.

Unit II deals with personnel factors and their influence on efficient functioning. Leadership, communications, motivations, job satisfaction, and the change process are discussed and their implications developed.

Unit III discusses the economic factors and their influence on efficient organizational functioning.

The chapter on budget planning is of great assistance to anyone who needs help with budget planning; the illustrations are helpful in assisting anyone working on a budget. Staffing patterns are discussed with eleven steps to proper staffing. Evaluation of nursing care is dealt with as well as the evaluation of nurse performance.

Some political influence and negotiations are also discussed. One author questions particularly the role of collective bargaining in nursing, suggesting that because nursing is a profession, it is not the trend for nurses to follow.

There are some excellent forms, charts and illustrations throughout the book e.g. evaluation of nursing services on a patient care unit.

The book is a useful book for nurses in the area of management. It is well written, concise and easy to read.

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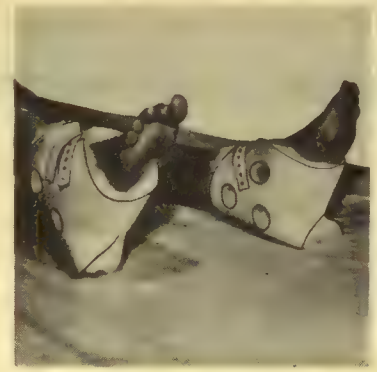
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Warnings
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Contraindications
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The following adverse reactions have occasionally been reported. Nausea, diarrhea, constipation, vomiting, dizziness, abdominal pain, skin rash and headache.

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During pregnancy, puerperium and lactation; and in multiple pregnancy: two tablets, in a single dose, should be swallowed daily.

Supplied
Each off-white film-coated Slow-Fe tablet contains 160 mg ferrous sulfate (50 mg elemental iron) and 400 mcg folic acid in a specially formulated slow-release base. Packaged in push-through packs containing 30 tablets per sheet and available in units of 30 and 120.
Full information available on request.

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CIBA
DORVAL, QUEBEC
H9S 1B1
C-6026R

See advertisement on cover 4

Canesten

Antifungal and trichomonacidal agent clotrimazole

PRESCRIBING INFORMATION

INDICATIONS *Canesten Cream and Solution* Topical treatment of the following dermal infections tinea pedis, tinea cruris and tinea corporis due to T rubrum, T mentagrophytes and Epidermophyton floccosum, candidiasis due to C albicans, tinea versicolor due to Malassezia furfur

Canesten Vaginal Tablets Treatment of vaginal candidiasis and trichomoniasis Canesten Vaginal Tablets may be used in both pregnant and non-pregnant women, as well as in women taking oral contraceptives (See Precautions)

DOSAGE AND ADMINISTRATION *Cream and Solution* Thinly apply and gently massage sufficient cream or solution into the affected and surrounding skin areas twice daily, in the morning and evening

For vulvitis, Canesten Cream should be applied to the vulva and as far as the anal region For balanitis and prevention of vaginal infection or reinfection by the partner, Canesten Cream should be applied to the glans penis

Vaginal Tablets One tablet a day for six consecutive days Using the applicator, insert one tablet deep intravaginally, preferably at bedtime In order to avoid treatment during menstruation, it is suggested that treatment be started at least 6 days prior to the anticipated menstrual period

DURATION OF TREATMENT *Cream and Solution* The duration of therapy varies and depends on the extent and localization of the disease Generally, clinical improvement with relief of pruritus usually occurs within the first week of treatment Tinea infections require approximately 3-4 weeks of therapy while in candidiasis 1-2 weeks treatment is often adequate If no clinical improvement is observed after 4 weeks, the diagnosis should be reviewed

If a cure is not mycologically confirmed or in order that relapses may be prevented (particularly in mycoses of the foot), treatment should, as a rule, be continued for 2 weeks after all clinical symptoms have disappeared

Vaginal Tablets The six-day therapy may be repeated if necessary

SPECIAL REMARKS *Cream and Solution* Added hygienic measures are of special importance in the management of the often refractory fungal diseases of the foot To avoid trapped moisture, the feet — particularly between the toes — should be dried thoroughly after washing

Onychomycoses, owing to their location and physiological factors, generally respond poorly to topical antimycotic therapy alone due to poor penetration into horny substance

Treatment with Canesten may be considered in cases of paronychia and as adjunctive therapy in onychomycoses following extraction or ablation of the nail

Vaginal Tablets Added hygienic measures such as twice daily tub baths and avoidance of tight underclothing is highly recommended

In the case of clinically significant trichomonal infection additional therapy with a systemic trichomonacidal agent should be considered Such therapy is essential for the treatment of vaginal infections which may also involve Bartholin's glands and the urethra

CONTRAINDICATIONS Except for possible hypersensitivity, Canesten Solution, Cream and Vaginal Tablets have no known contraindications

PRECAUTIONS As with all topical agents, skin sensitization may result Use of Canesten topical preparations should be discontinued should such reactions occur, and appropriate therapy instituted

Canesten Solution and Cream are not for ophthalmic use

Canesten Vaginal Tablets are not for oral use

Use in Pregnancy: Although intravaginal application of clotrimazole has shown negligible absorption from both normal and inflamed human vaginal mucosa, Canesten Vaginal Tablets should not be used in the first trimester of pregnancy unless the physician considers it essential to the welfare of the patient

The use of the supplied applicator may be undesirable in some pregnant patients, and digital insertion of the tablets is an alternative which should be considered

SIDE EFFECTS Large scale clinical trials have shown that Canesten is very well tolerated after topical and vaginal application

Cream and Solution: Erythema, stinging, blistering, peeling, edema, pruritus, urticaria, and general irritation of the skin have been reported infrequently

Vaginal Tablets: Skin rash, lower abdominal cramps, slight urinary frequency, and burning or irritation in the sexual partner, have occurred rarely In no case was it necessary to discontinue treatment with Canesten Vaginal Tablets

AVAILABILITY *Canesten Solution* 1% is supplied in 20 ml plastic bottles, in carton Each ml contains 10 mg of clotrimazole in a non-aqueous vehicle

Canesten Cream 1% is supplied in 20 g tubes, in carton Each g contains 10 mg of clotrimazole in vanishing cream base

Canesten Vaginal Tablets 100 mg are supplied in boxes containing one strip of six tablets with plastic applicator and patient leaflet of instructions

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For further prescribing information please consult the Canesten Product Monograph or your Boehringer Ingelheim representative

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2121 Trans Canada Highway
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FBA-91-77

See advertisement on page 5.

(Continued from page 57)

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Head Nurse required for a 41-bed unit in our Health Centre for Children. Patients ages range from newborn to early adolescence and mainly have a neurosurgical or neurological diagnosis. Head Nurse also assists others in planning care of pediatric neurology patients who are (due to age) admitted to other units. Applicants should have competence in the field of pediatric neurology and neurosurgery. Apply to: Vancouver General Hospital, Employee Relations Department, 855 West 12th Avenue, Vancouver, British Columbia. V5Z 1M9

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Closure of St. Joseph's Regional School of Nursing. This school which became the St. Joseph's Campus, Fanshawe College in September, 1973 is no longer operational. References, transcripts, etc. can be obtained as follows for graduates and employees. **Prior to September 1, 1973:** Department of Nursing Service, St. Joseph's Hospital, 268 Grosvenor Street, **London,** Ontario, N6A 4V2. **After September 1, 1973: Students:** Registrar's Office, Fanshawe College, P.O. Box 4005, Terminal A, **London,** Ontario, N5W 5H1. **Staff:** Dean, Health Sciences, Fanshawe College, P.O. Box 4005, Terminal A, **London,** Ontario, N5W 5H1

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III. Applications close November 15, 1977.

IV. Appointees are expected to take up duties on 15th January, 1978.

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The Province of British Columbia

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the canadian nurse

November, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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It's a long, long way from Victoria, B.C. to Salonica, Greece, but that's where the marchers on the cover were headed. The year was 1915 and the marchers were the Nursing Sisters of No. 5 Canadian General Hospital getting ready to board the train for a trip across Canada before beginning their tour of duty overseas. This month, CNJ salutes all of the registered nurses who served their country in that war and the ones that followed. Our **Cover Photo** appears with the kind permission of the family of the late Gladys Stewart of Victoria, B.C.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Guidelines for authors

Who can write for *The Canadian Nurse*?

Anyone with information or ideas to share with members of the nursing profession in Canada may submit this material — manuscript, cartoon, photo or other original communication — to the editor for consideration.

How are articles chosen for publication?

Manuscripts submitted for publication are acknowledged on arrival and subsequently reviewed in detail by the editorial staff. The criteria used for selection of articles for publication include:

- originality
- timeliness
- significance and scope
- reader appeal

In reviewing manuscripts the editorial staff also take into consideration plans for special or theme issues in coming months and coverage already given to a particular topic in previous issues of *The Canadian Nurse* and other nursing journals. That's why, if you're planning to submit an article, it is always a good idea to send a letter of enquiry beforehand, outlining your subject matter and treatment. This will enable the editorial staff to provide you with the appropriate editorial guidance and let them know that this material will be available at a later date.

What makes a good article?

The selection of editorial content for any publication is a subjective process but an article is more likely to be accepted IF:

1 It deals with an interesting subject, i.e. a new program or procedure, a better way of doing something, or an individual interpretation of an issue or concern.

Because *The Canadian Nurse* is a professional nursing journal dedicated to enhancement of the profession, we particularly welcome clinical articles that promote improvements in nursing care and also research articles that advance the level of nursing practice and knowledge.

2 The author is knowledgeable and informed about the subject he chooses. **Controversy is not only acceptable but welcome**.

3 The style of presentation is personal, informal and readable. **The communication process bogs down under the weight of big words and roundabout ways of saying things**.

What happens when an article is accepted?

Editing involves checking factual content, adding new information, deleting unnecessary material and revising what remains to meet an accepted grammatical, spelling and writing style.

Sometimes the author is asked to help with this process; usually a member of the editorial staff does the work, but the author is always consulted before publication. Any changes made after the author has indicated his/her approval will be minor ones dictated by make-up considerations.

A word about references

References and bibliographies are published to provide readers with the resources they need to pursue their own study of the subject under discussion in an article. In order to be useful they must be complete. This means indicating the full name of the author, the correct title of the book, place and date of publication, the name of the publisher and (in the case of periodicals) name of the journal, the volume, year and pages consulted, as well as the author, and title. It is helpful but not necessary to provide this information in the order and style preferred by *The Canadian Nurse*.

What about length?

There is no minimum length for articles but most short articles are about 500-750 words (about four or five typewritten, double-spaced pages). Articles of more than twelve pages will probably require editing to a more readable length. **Be your own preliminary editor. Always check your material over carefully and condense it wherever possible before submitting it**.

Would pictures help?

Illustrations — photos, drawings, graphs — are always eye-catching and often make the difference between a so-so article and an interesting one. Black-and-white glossy photographs are best but slides and color photos can be adapted.

How do I go about submitting my article?

You will need three copies of your manuscript — typed, double-spaced on standard white bond 8 1/2 by 11 inch paper. Mail two copies (keep one for your records) along with a covering letter containing a brief biographical sketch of yourself as the author, to:

The Editor,
***The Canadian Nurse*,**
50 The Driveway,
Ottawa, Ontario,
K2P 1E2.

Good luck! ... The Editor ...

Perspective

When those of us who are a part of what has been called the Me Generation think of conservation, we are apt to think of it as a relatively recent phenomenon. We forget what those who lived through a catastrophe such as the Hungry Thirties or either of the two World Wars, know all too well — that conservation may not always be a matter of individual choice.

Sixty years ago, the catastrophe of war brought home the message of conservation to another generation of readers of *The Canadian Nurse*. Mary Campbell MacQueen, writing in the October 1918 issue of CNJ says that "the word conservation is on the lips of everyone, it is used almost as much as efficiency and co-operation." She urges readers to avert disaster by "reducing the amount of necessities, comforts and luxuries which the civilian population consumes. Take, for example, the waste in fuel, keeping houses unhealthily hot; having needless clothing, needless servants; excessive eating and drinking, and a full garbage can.

"There are so many ways and things in which we could save. Take, for instance, sugar. Forty-five percent of the sugar consumed in the United States and Canada is used in the manufacture of candy and like luxuries, and the consumption of candy on this continent has increased enormously in the past year, and now we are about to be placed on sugar rations. Butter is scarce, and the Allies need fat perhaps more than any other article of food; still, Toronto alone uses 778,479 lbs. of butter fat every year for ice-cream.

"...In hospitals where little things mount so rapidly and count for so much, there are a few "don'ts" we might remember: Don't heat food in a pan without water; don't use coarse scouring powder; don't throw away clippings of gauze or cotton; don't scrape pans: soak them; handle utensils with care. Where numbers have to be fed, the cafeteria plan has proved economical; the loaf and breadboard on the table saves bread, both from being wasted and becoming stale. Barbers' towels are very absorbent and have effected a great saving in gauze dressings. They have been satisfactorily used instead of the combined absorbent and gauze final on abdominal and other wounds; a few strips of gauze are put next the incision and the folded towel over this. Also, in the maternity wards, they save vaginal pads. For fresh cases, pads of absorbent cotton and gauze are used reinforced with a sterilized towel, and after the first few days towels are substituted altogether. It requires a woman to wash these towels before being sent to the laundry, but that is much easier to have done than to procure gauze and cotton.

"There are not nearly so many dishes broken when each one has to report every article she breaks. The same applies to rubber goods and thermometers; and the requisitions for dressings will not be so large if each ward is asked the exact number of dressings to be done in twenty-four hours."

In 1918 it was sugar rationing and barbers' towels. Today it is car pools and compost heaps. Sixty years ago, it was commonly believed that the return to normal productivity that accompanied the cessation of hostilities would signal an automatic and permanent end to the scarcities that had characterized the war years.

Six decades later we are gradually coming to the realization that things are not quite that simple. The Science Council of Canada, in its most recent report, "Canada as a Conserver Society," says that from now on we must work together to make conservation not consumption the basis of our social order. The author of the report, University of Toronto professor and Science Council member Ursula Franklin, warns that "We don't have to, in fact, we mustn't depend on catastrophe to change us. It is only by being intelligent... by changing the style of some technologies, that we shall find room for continuing growth... (and) keep our options open, rather than being driven, by one supply crisis after another, to desperate solutions."

How far away is The Conserver Society? Let's hope it won't take another sixty years for this generation to find an acceptable solution.

— **M.A.H.**



Herein

Authors **Alison Rice** (above) and **Elaine Carty** (right) are doing more than just talking about alternatives to the traditional hospital birth experience. They are also engaged in planning an alternative to conventional hospital delivery in Canada. Together with colleagues at the University of British Columbia, they are working on formulating a proposal for a demonstration project using nurse-midwives, nurse specialists, obstetricians and pediatricians to provide comprehensive care for low risk women and their families in a small out-of-hospital birth center. For a look at what has already happened in the U.S., see "Alternative Birth Centers" on page 31.

"You have been selected as nursing sister for service abroad. Report Quebec 23rd September." The order to mobilize Canada's Army Nursing Service went out within weeks of Germany's refusal to withdraw troops from Belgium as demanded in the British ultimatum of August 4, 1914. By the first week of October, the first convoy was steaming across the Atlantic from Canada and before the end of that year more than 50 Canadian nurses had crossed the Channel to begin active service in Europe. **This month,** in the second instalment of "Four Score and Ten," Maude Wilkinson remembers those war years — the mustard gas and champagne, the casualties and the comrades.



Next month, author Jean Gurr of Montreal, describes a school screening program for scoliosis that really works! A team of health professionals including school nurses from the Department of Community Health at the Montreal General Hospital, medical consultants at the Shriner's Hospital for Crippled Children, physiotherapists and others, operate the program. It has proven to be effective in detecting new cases of scoliosis in adolescents, in providing comprehensive follow-up that involves family teaching and in lowering health care costs.

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The Canadian Nurse invites your letters. All correspondence is subject to editing and must be signed, although the author's name may be withheld on request.

Input

Symbol of competence

For some months now I have been concerned over the apparent decline in the graduate nurse's pride in one of the "badges" of her profession — namely her cap. In our hospital the only nurses who are required to wear a cap are the students. For the rest of us it is an option and increasingly more and more nurses are going capless. We are also allowed to wear any style and color of uniform or pantsuit as we see fit.

It is no wonder that the patient, as well as the doctors and visitors often have a hard time in deciding who is a nurse and who isn't. I have heard complaint after complaint from patients, doctors and visitors about this fact. The only person they are sure is a nurse is the student because she wears her cap.

I still remember the day I received my cap — one of the highlights in my life. I worked hard for it and am proud to wear it.

I feel that some of the deterioration that is often apparent in our profession starts with lack of personal pride in our outward appearance — dirty shoes, runs in stockings, long straggly hair, fancy uniforms etc. and now no cap. I personally feel that a certain standard in uniform is a good thing but is that possible when the director and assistant director of nursing and many of the instructors do not even wear a uniform let alone a cap?

Am I being old fashioned or are there others who feel as I do?

— D. Sullivan, Victoria, B.C.

Epilogue...

Since I wrote "A Canadian Grad Goes to the States" (October 1977), I have returned to live in Canada. So it seems that all the problems I outlined in my article finally did cause me to come back home. I am currently living in Windsor and am about to start a new job in Detroit as an emergency room outpatient clinic nurse. So although I am back in Ontario, the job situation still forces me to work in Detroit for the opportunities I want ...

— Katherine Zin, R.N., Windsor, Ontario.

Keeping up with the times

I have been planning to write for months and comment on how much I am enjoying the "Update" articles and the Wordsearchs that are in *The Canadian Nurse*.

I find them informative and very useful in keeping up with current practices. Since I live in an isolated community and, owing to this location, am not working, I enjoy the monthly reviews that these articles give.

Keep up the good work!

— B. Fiddes, R.N., Lac Seul, Ont.

Special community service

I always enjoy my copies of *The Canadian Nurse*, but July 1977 was, for me, the tops.

It was nice to see news published of the "Future for V.O.N." and to read the report on Expanded Roles in Respiratory Nursing.

Here at the North Shore Branch of the V.O.N. in North and West Vancouver, B.C., we have started this year, a special service to the community, mainly for chronic respiratory patients. We are fortunate in having three hospital out-patient rehabilitation areas in Greater Vancouver but those who are unable to get to these areas are seen in the home upon referral.

At present, I am the only nurse in this Home Service and find it very interesting to hear of other places and what they are doing there.

— Ruth Darby R.N., V.O.N. Respiratory Nurse, Vancouver, B.C.

People power

I would like to start a campaign called "The Pantyhose Ripoff."

It is time women demanded better quality pantyhose. The manufacturers need to be told that we expect better value for our money. That we want pantyhose with a month guarantee or money refunded.

For this campaign to work I would need women all across Canada to write a similar letter to the editor of their local paper and also to let all the stores know.

Everyone should save their throw-away pantyhose and return them to the store.

— Kathleen Crowley, R.N., Fredericton, N.B.

Island in the sun

I would like to say how much I enjoyed Jane Graydon and Judith Hendry's article "Outpost Nursing in Northern Newfoundland," but was disappointed with the map that accompanied the article.

Did you not know that the land north of Nova Scotia and New Brunswick is a Canadian province called Prince Edward Island — P.E.I. for short? Anticosti Island isn't even a province and yet it was clearly marked. Surely P.E.I. wouldn't have taken much room on the map!

This may seem petty griping but to some of us "Islanders" it was sheer neglect.

I know a visit to our fair island the "Cradle of Confederation" would imprint P.E.I. on your readers' memories forever.

— M. Hughes, R.N., Charlottetown, Prince Edward Island.

Editor's note: *To each and every one of CNJ's 888 readers in the Cradle of Confederation — our sincere apologies.*

A stimulating issue

The September '77 issue was the most provocative and informative in a long while. Ella MacLeod's letter on the use of the word chairperson deserves a wide reading. It makes sense.

Mohamed Rajabally's "Nursing Education: Another Tower of Babel" was thoroughly enjoyed by a number of people I have spoken with as well as myself. It was spirited, provocative and engaging.

More writing on these controversial issues would be welcomed by many readers. Let's also see articles like "The Tri-Hospital Diabetes Education Centre" in future issues. It was exceptionally well written and packed with information for anyone involved with this disease.

— Nancy Kyle, Montreal, P.Q.

Nursing's inherent validity

I would like to thank Mohamed Rajabally for thinking, and *The Canadian Nurse* for printing, his thoughts on nursing education. For a long time I have thought that nursing is not complicated in the way that its educational theorists suggest; *sub rosa* I have wondered about overcompensation and reaction formation.

Although I do not at all subscribe to an anti-intellectual approach to nursing, I do not believe that imposing a pseudoscientific superstructure on what is essentially an applied art will give nursing validity. Nursing synthesizes many disciplines — medicine, epidemiology, sociology, psychology, to name the obvious ones. Its essence, it seems to me, is an intelligent and informed caring or mothering.

Nursing, like mothering, is often devalued at the present time. I have noticed that as I become less defensive about being a nurse — with all the connotations of second-class hospital citizenship that it can imply — and have recognized both the contributions and the limitations of my occupation, I have had less need to prove that nursing is a science, a profession, a high-status job by virtue of the complicated theory surrounding it.

— (name withheld) Montreal, P.Q.

Working nights

I would like to add one idea to the article on shift work. I am wholly in favor of permanent shifts. I believe that if the positions were advertised as such and there were sufficient differential in pay, there would be no difficulty in obtaining staff.

— Mary Lobb, R.N., Winnipeg, Man.

Did you know ...

Regina Grey Nuns' School of Nursing, Class of '73 are interested in having a five-year reunion tentatively scheduled for May 28, 29, 1978. But they need your support. If you are interested in attending the reunion contact: Reunion Committee, 4721 Pasqua Street, Regina, Saskatchewan, S4S 6N7.



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News

MARN hosts first national seminar on standards of nursing practice

The first national gathering of nurses concerned at the provincial level with the development and implementation of standards of nursing practice ever held in Canada took place in Winnipeg on the last two days of September this year. The meeting was convened by the Manitoba Association of Registered Nurses and attended by a total of 21 nurses, including representatives from eight provinces and the Northwest Territories.

Also present were Norah O'Leary, nurse adviser, Health Standards Directorate, Health Programs Branch, Health and Welfare Canada; Rose Imai, recently appointed director of professional services, Canadian Nurses Association, and Miriam Pill of the Canadian Council on Hospital Accreditation.

The chairman of the meeting, Deidre Blank, nursing consultant, standards for the Manitoba Nurses Association, welcomed participants to the meeting. She explained that the MARN decision to host the standards meeting was based on the desire to provide provincial counterparts with a forum for sharing information on progress within the various jurisdictions towards the development of standards of nursing practice at a provincial level.

Day one of the two-day meeting therefore was devoted largely to explanations and descriptions of relevant programs by the various provincial spokesmen. As the discussion proceeded, wide variations in interpretation and approach between the various jurisdictions became apparent. A minority of provinces (notably British Columbia, Saskatchewan and Manitoba) have some sort of quality assurance program, incorporating standards of nursing practice, already in effect. Others, such as Alberta, are now in the process of developing nursing practice standards for approval by their membership.

In spite of the differences which surfaced, participants reached agreement on two important points:

- there is no "right or wrong" approach; each province must proceed on the basis of its unique situation towards a goal that is acceptable for that province.
- there is a very real need for action at the national level to provide the provinces with guidelines that will allow them to proceed from a unified base towards the implementation of national standards of nursing practice.

Norah O'Leary, whose position as nurse adviser with Health and Welfare Canada involves coordinating and facilitating work on guidelines and standards of nursing practice at the national level, outlined progress on national standards to date.

"One of the priorities of the Canadian Nurses Association over the past two years has been the development of a definition of nursing practice and the establishment of national standards," she said. The association is now working jointly with the Health Standards Directorate on this project. O'Leary, who assumed this post in July, will work with a 14-member National Steering Committee composed of representatives of the provincial/territorial nurses associations and provincial governments.

Nurses who attended the Winnipeg meeting agreed that their efforts should be considered as helping to lay the groundwork for this National Steering Committee which will hold its first meeting early in 1978. They also agreed that, in order for the project to be a success, the CNA should act to ensure that an evaluation component is included in the work on national standards. Their recommendation will be forwarded to CNA directors for consideration at the October board meeting.

Emergency Nurses hold sixth annual conference

Emergency nurses from all parts of Ontario took a long look at some common concerns at the sixth annual conference of the Emergency Nurses Association of Ontario (ENAO). Some 300 delegates met in Ottawa for the lively three-day meeting, including some nurses from Quebec and Manitoba.

The program of the conference was geared specifically to the educational needs of emergency nurses. Guest speakers discussed a number of topics pertinent to the emergency nurse. These included obs-gyn emergencies, hematological crisis, ENT, dental and urological emergencies, GI crisis, sudden infant death syndrome, dialysis in the ER and emergency plastics.

A panel discussion dealt with the subject of death in the emergency department. Jill Courtemanche, R.N., talked about how the nurse in emergency can help the relatives of a deceased patient. Dr. James Dickson, coroner for Ottawa-Carleton discussed the medico-legal aspects of death in the emergency room. Rev. Dr. John Swift, chaplain at Queensway-Carleton Hospital in Ottawa, talked about the grieving process and the use of grief workers to help those whose relatives have died in the hospital.

Another interesting and very helpful presentation at the conference was Penny Jessop's well-demonstrated instruction in the A.B.C.'s of cardiopulmonary resuscitation. The coordinator of the Ambulance Training Program of the Ontario Ministry of Health, Jessop explained the need for standards for the application of CPR and outlined clearly the steps to be taken in the cases of witnessed cardiac arrest, unwitnessed arrest, arrest in infants, and obstructed airways.

The ENAO has come a long way since its first annual conference attended by 75 members in November of 1971. Membership now stands at approximately 800 nurses.

The purpose of the ENAO is to upgrade emergency nurses within their own specialty:

- to teach and exchange ideas
- to improve community relations and communications by becoming more knowledgeable about individual hospital problems and patient needs
- to establish a program geared specifically to emergency nursing in order to improve the care given to patients in emergency.

ENAO is affiliated with the Registered Nurses Association of Ontario, and has been involved with interdisciplinary groups such as the Ontario Medical Association and the Association of Casualty Care Personnel.



The executive of the Emergency Nurses Association of Ontario at their sixth annual conference. Seated (left to right) are Kathleen McPhee, the first president of ENAO; Gail Lounds, president; and Kathleen Kitney, past president. Standing (left to right) are Cathy Barbour, vice-president; Margaret Pook, secretary; Diane Dixon, past editor; Mary Arntfield, business secretary; and Hilda Powis, past treasurer.

Members back MARN at special meeting

Close to 1,000 nurses attended a special general meeting of the Manitoba Association of Registered Nurses held in early October, the largest attendance at any general or annual meeting in the history of the Association.

The meeting was called in response to a request of association membership, who indicated seven items that they wished to have discussed. At the time CNJ went to press, only four of these items were available.

Collective approval was given to the following resolutions:

- that the Board of Directors investigate the feasibility of a Post-Diploma Baccalaureate program for registered nurses in Manitoba after receipt of the report from the Manitoba Government of the Joint Ministerial Task Force on Nursing Education and further information on the progress of the development of a B.N. program at the University of Brandon and .... that the Board of Directors encourage that the entrance requirements of the two-year program be the successful completion of R.N. examinations.
- that the membership go on record as reconfirming the decisions made with respect to their direction to and support of The Board of Directors' decisions taken to date regarding the position paper "Nursing Education: Challenge and Change."
- that in the opinion of the membership, the conduct of the Board of Directors in negotiating with the Service Employees International Union, Local 308, was fair and reasonable.

A resolution was passed at the May annual meeting to promote the development of a Baccalaureate nursing program at Brandon University. A progress report on this resolution was presented and accepted by the assembly at the October meeting.

Members attending were given every opportunity to participate in discussion on all items on the agenda, and many availed themselves of this opportunity. Comments made would indicate that members are interested in their professional Association and desirous of participating in and

Nurses try out fitness model

Twenty-three nurse educators from community colleges, hospitals, and universities across Canada met early in September to immerse themselves in health, fitness and lifestyles as part of CNA's Health Promotion Project, Phase Two.



The lively five-day workshop held in the YMCA Conference Centre, Geneva Park, Ontario brought together provincial and territorial delegates who were chosen by CNA's member associations. Helen Mussallem, executive director of CNA and Joan Gilchrist, CNA president were also in attendance for part of the conference.

The program, which included many well-known speakers, was a mixture of theoretical information, idea sharing and practical sessions of fitness tests, exercising, eating nutritiously and generally "getting involved."



CNA project officer, Jean Everard, stated that the expected result of the conference was to effect a personal change in the nurses who attended so that they would act as "role models" to nursing students and to nursing faculty members with whom they come in contact.

Funding for the workshop and much of the fitness expertise were supplied by Recreation Canada, Fitness and Amateur Sport Branch.

This follows the trend fostered by Iona Campagnolo, Minister of State for Fitness and Amateur Sport, to provide more opportunities for all Canadians to be involved in exercise. Mall Peepre, fitness consultant with the Branch, stated that of all the health





professions, nursing has shown the greatest interest in a health promotion scheme. Workshops of this kind where individuals are in the "living situation" for five days work towards changing attitudes about fitness and lifestyle.

The nurses attending the conference were able to express their criticism, ideas and suggestions through a questionnaire handed out at the workshop. A follow-up questionnaire will be sent to all the delegates in six months time.

Later this year, CNA will request further funds for health promotion workshops for public health nurses and occupational health nurses.



Those attending the workshop were: Back row, L to R: Joan Gilchrist, CNA president; Betty Rideiro, Nfld.; Sharron Woodworth, N.B.; Alexa Brewer, Ont.; Patricia Kurki, Ont.; Maureen Murphy, B.C.; Jean Innes, Sask.; Nancy Wiggins, N.B.; Joan Royle, Ont.; Nida Davediuk, N.W.T.; Barbara Stewart, P.Q.; Margot Phaneuf, P.Q.; Helen Mussallem, CNA executive director. Middle row, L to R: Sandra Murphy, Nfld.; Jean Everard, CNA project director; Judy MacIntosh, P.E. I.; Leslie J. Robert, Alta.; Loni Sarsfield, Sask.; Donna Meagher, N.S.; Bonnie A Friesen, Alta.; Janet Lindquist, N.W.T.; Mall Peepre, fitness consultant, Ottawa. Front row, L to R: Marilyn Mitchell, Man.; Nettie Peters, Man.; Laurie Clarke, B.C.; Laura Saulnier, N.S.; Ginette Premont, P.Q.

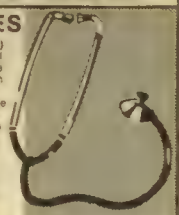
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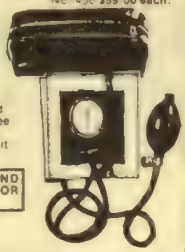
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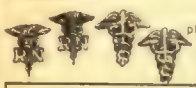
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VGH reorganizes nursing department

The nursing department at the Vancouver General Hospital, Vancouver, B.C. has recently undergone a major reorganization. Each of five nursing specialties now constitutes a department headed by a clinical nursing director who brings to the position the specialized knowledge and competence required to organize and deliver nursing care. The five clinical nursing directors are members of the hospital's Nursing Advisory Committee which has developed as a nursing parallel to the Medical Board. The Committee's responsibilities deal particularly with the development of quality assurance program for nursing care and recommendations for nursing policies.

The five newly appointed clinical nursing directors are: Anne Jenkins, director, Pediatric Nursing; Bonnie Lantz, director, Surgical Nursing; Winifred M. Miller, director, Psychiatric Nursing; June Nakamoto, director, Obstetrical, Gynecological Nursing; Lorea Ytterberg, director, Medical Nursing.

The newly created staff position of director, Nursing Administrative Services, has been filled by Thurley M. Duck.



Thurley M. Duck

As director, she is secretary to the Nursing Advisory Committee and is responsible for the development of the quality assurance program in nursing.



Winifred M. Miller

The four years of studies and planning for the reorganization carried out by the nursing staff and hospital, revealed that a great deal of nursing staff time was being spent on activities related to nursing, but not actually nursing functions. To allow nursing staff more time for direct patient care, an administrative support team for nursing has b been established. Clara Y. Lim has been appointed director, Nursing Support Services. She will supervise four administrative managers.

The nursing reorganization was implemented at VGH to give nursing staff the opportunity to devote more time to the care of patients and to work more closely with the physicians at the hospital. It is part of a plan to enhance both job satisfaction for nurses and to maintain a high quality of health care for patients.



Clara Y. Lim

RNAO's nursing process project underway

A two-year project to assist in the implementation of the nursing process by all nurses throughout Ontario is well underway.

In November, 1976, the Registered Nurses Association of Ontario's board of directors authorized the project as a follow up to the Team Nursing Project. The nursing process project aims to increase the effectiveness of the nurse in her practice of nursing, to endorse the Standards of Nursing Practice recently issued by the College of Nurses of Ontario, and to assist hospital nursing departments carry out accreditation guidelines.

The objectives of the project are:

- to promote utilization of the nursing process by all registered nurses throughout the province;
- to develop the skills of the registered nurse in assessment of patient needs, planning for nursing care, implementing the plan through appropriate nursing action and evaluation of the outcome of nursing care; and
- to improve the problem solving abilities of registered nurses.

The project consists of three phases:

Phase I: An initial series of workshops on the nursing process on a regional basis throughout the province.

Phase II: A follow-up series of workshops approximately one year later.

Phase III: Documentaton of all activities and evaluation of the results.

In June 1977, Louise Lemieux Charles was appointed project co-ordinator. Since then, a provincial steering committee, acting as a co-ordinating body for the project, has developed guidelines outlining the basic principles on which the workshops will be based.

Regional planning committees representing RNAO's six regions have been formed. The committees will identify the specific educational needs of their area in relation to the nursing process and identify available community resources.

Seven workshops will take place in late November 1977. Another two regional planning committees will meet soon to plan further workshops.

News

First Psoriasis Education and Research Centre

The Women's College Hospital in Toronto has opened Canada's first Psoriasis Education and Research Centre (PERC). The cost of treating a patient at this center is estimated at one-third the cost of hospital treatment.

Psoriasis, a chronic recurrent skin condition characterized by flaking, scaling, and itching of the skin has been estimated to affect between 800,000 and 1,000,000 Canadians of both sexes, and all ages, racial origins and social levels.

The Education and Research Centre is set up to treat those patients with extensive disease that have previously required hospitalization to meet their need for treatment. In addition to a flexible education program, the Centre draws up treatment schedules that are individually tailored to meet the patient's work pattern and lifestyle.

At the Center, a patient is taught the skills of skin care as well as learning how to minimize disability. He learns how to maintain remission, how to recognize and treat relapses at an early stage. He is encouraged to function at an optimum level, and to be independent.

The objectives of the program are:

- to teach patients to care for themselves and recognize their symptoms before the condition becomes full-blown
- to provide a center for training medical, nursing and other professionals in methods of comprehensive and preventative care of chronic skin conditions
- to develop a less costly alternative to hospitalization while maintaining a comprehensive program.

PERC is a demonstration model for which operating funds were provided by the Atkinson Charitable Foundation, the federal government, Health and Welfare Canada research grants and the Women's College Hospital.

Bégin replaces Lalonde in cabinet shuffle

Canadians have a new minister of National Health and Welfare. She is the Hon. Monique Bégin, P.C., M.P. for the Montreal riding of Saint-Michel. Her appointment became effective September 16 of this year.

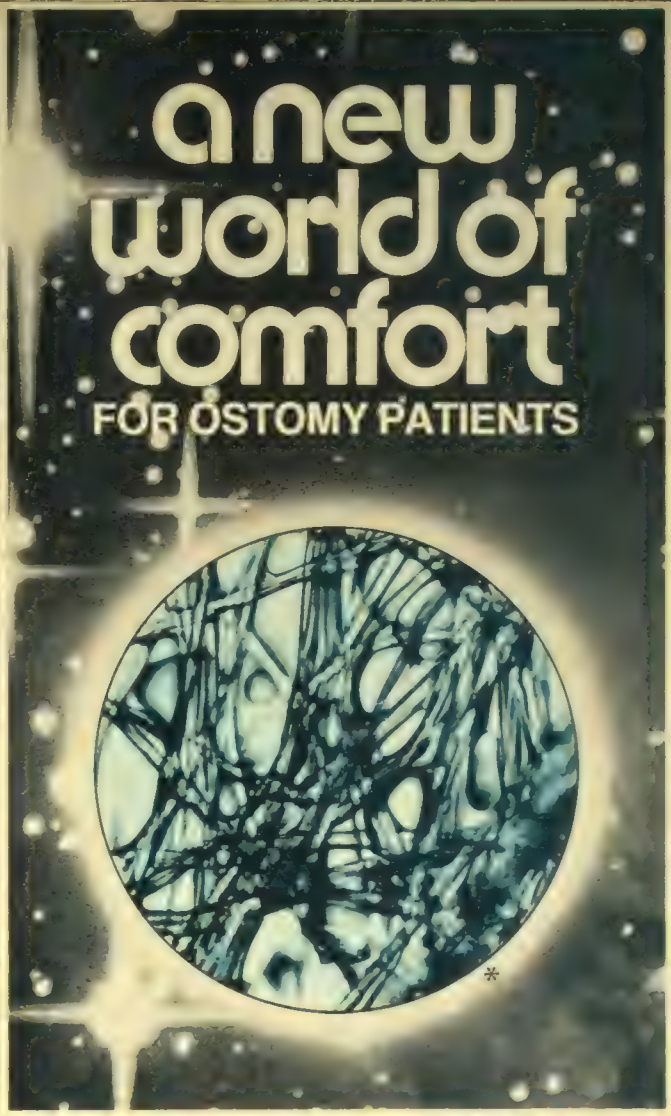
First elected to the House of Commons in 1972, Bégin was formerly Minister of National Revenue (since September, 1976) and Parliamentary Secretary to the Secretary of State for External Affairs.



Bégin has served on several parliamentary committees, including External Affairs and National Defence, Broadcasting, Health and Social Affairs, and Immigration.

In 1973, she was a member of the Canadian Delegation to the Commonwealth Conference held in Ottawa and served as a permanent delegate of the 28th session of the United Nations in New York. She was head of the Canadian ministerial delegation, 25th Conference, Colombo Plan in Colombo, Sri-Lanka.

Bégin was born on March 1, 1936 in Rome, Italy and was educated in Montreal. A former teacher, she obtained her M.A. (Sociology) from the University of Montreal, followed by doctorate studies at the University of Paris and post-graduate courses at the Engineering Faculty of McGill University in Montreal. She worked in the private sector on applied social research projects, before being appointed executive secretary of the Royal Commission on the Status of Women. She was also administrator of the research branch of the C.R.T.C.

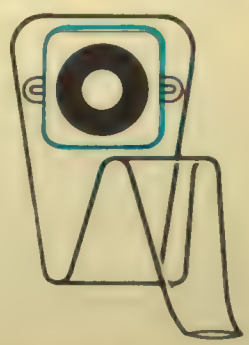


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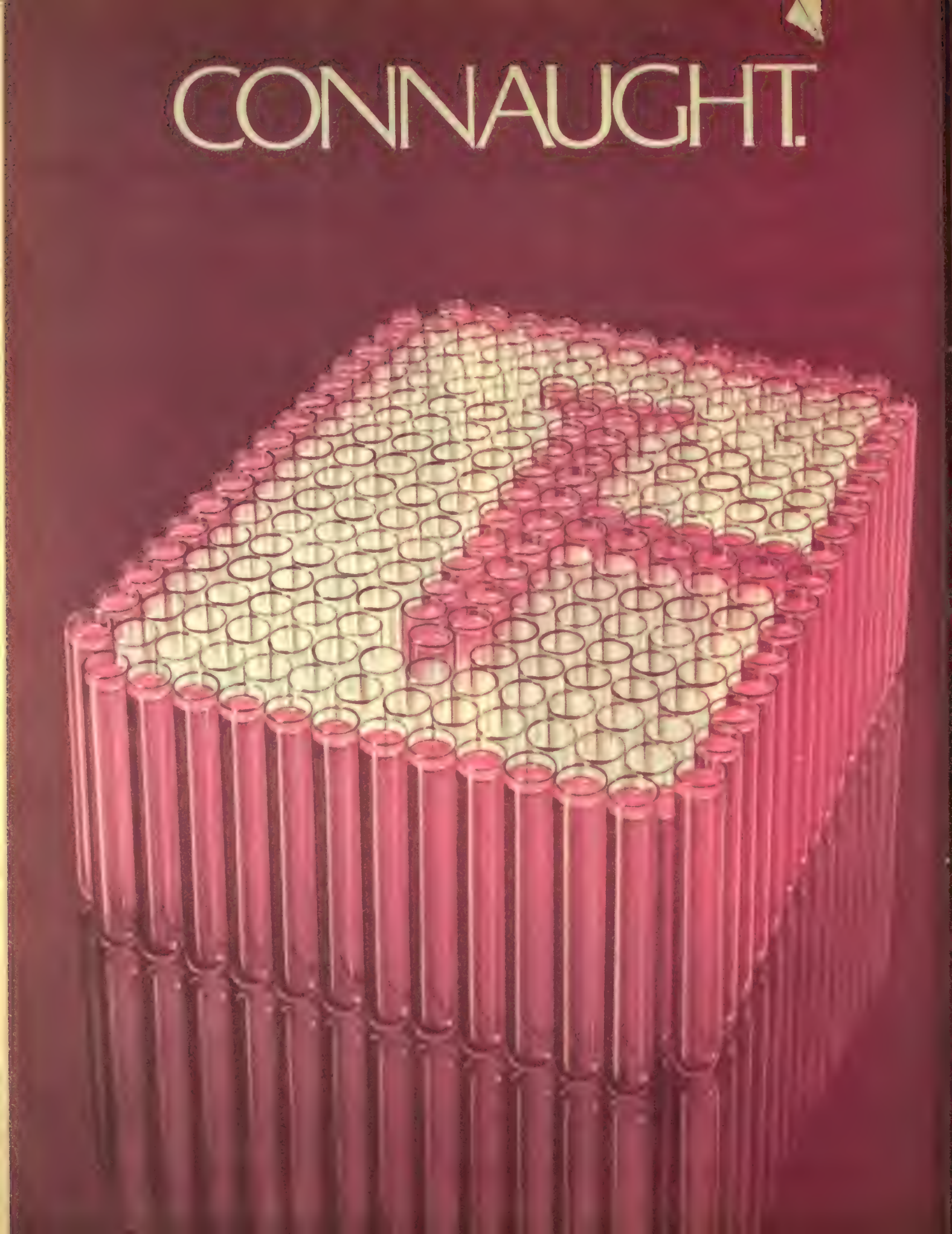
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JUNE

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Toronto's Great in '78 for the CNA convention.

Holding a conference or meeting soon? If you are, CNJ wants to know about it and so do our readers. But due to production deadlines, we must have the dates at least two months in advance for inclusion on the "Calendar" page. Send your conference dates to: *Calendar, The Canadian Nurse, 50 The Driveway, Ottawa, K2P 1E2.*

November

Coping with Work Stress. A one-day workshop to be held at the University of Victoria, Victoria, B.C. on Nov. 25, 1977. Fee: $15. Contact: *Division of Continuing Education, Mrs. F.B. Collins, Programme Officer, University of Victoria, Box 1700, Victoria, B.C., V8W 2Y2.*

Annual Seminar of the Manitoba Operating Room Study Group in conjunction with the Manitoba Health Organization Conference. To be held on Nov. 22, 1977. Contact: *Faith Yundak, Operating Room, Children's Centre, 685 Bannatyne Ave., Winnipeg, Manitoba, R3E 0WI.*

Symposium on the High Risk Infant and Family, to be held on Nov. 30 and Dec. 1, 1977 at the Netherland Hilton Hotel in Cincinnati, Ohio. Presented by the University of Cincinnati College of Nursing and Health. Contact: *Michael Hyre, Executive Director, Greater Cincinnati Chapter, The National Foundation, March of Dimes, 324 East Third A St., Cincinnatti, Ohio, 45202.*

Children and Infection. A one-day conference to be held on Nov. 23 and on Nov. 30, 1977 at the Hospital for Sick Children, Toronto. Fee: $20. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G 1X8.*

December

Primary Health Care in Industrialized Nations to be held on Dec. 12-14, New York City. Contact: *Conference Department, The New York Academy of Sciences, 2 East 63rd St., New York, N.Y. 10021.*

Common Problems in Orthopedics to be held on Dec. 8-10, 1977 in Saskatoon. Contact: *CME Office, University of Saskatchewan, 408 Ellis Hall, Saskatoon, Sask., S7N 0W8.*

Call for papers for the 1978 Annual Meeting of the American Thoracic Society to be held in Boston, Mass. on May 14-17, 1978. Papers on all aspects of respiratory disease are welcome. Abstract in English, to be in no later than Dec. 7, 1977. Contact: *Richard H. Winterbauer, M.D., Chairman, ATS Annual Meeting Committee, American Thoracic Society, 1740 Broadway, New York, N.Y. 10019.*

Training for Adult Educators. A series of interprofessional seminars to be held in Vancouver: Dacum — A systems approach to training on Nov. 25-26; Design and management of instruction on Dec. 2-3; Research for the practitioner — the practitioner as researcher on Dec. 9-10. Fee for all seminars: $50.
Contact: *Registrations, Centre for Continuing Education, U.B.C., Vancouver, B.C. V6T 1W5. (604) 228-2181.*

Conference for Senior Nurse Administrators to be held at the Ontario Hospital Association in Toronto on Dec. 5-6. 1977.
Topic: Employee Relations; Assertiveness Training. Contact: *Norma Clark, Coordinator, Nursing Services, Ontario Hospital Association, 150 Ferrand Dr., Don Mills, Ontario.*

Seminar Series on the Organization and Delivery of Mental Health Services to be held on Dec. 9-10, 1977 in Austin, Texas. Contact: *Anne E. Parsons, Community Relations Officer, Thistletown Regional Centre, 11 Farr Ave., Rexdale, Ont., M9V 2A5.*

Current Practices in Breast Feeding and Maternal Infant Bonding to be presented in Winnipeg on Dec. 2, 1977. Fee $10. Contact: *Norma Buchan, Women's Centre, Health Sciences Centre, 700 William Ave., Winnipeg, Man., R3E 0Z3.*

January, 1978

Overview of Paediatric Rehabilitation Course: A Multidisciplinary Approach to Management. To be held in Toronto on Jan. 23-27, 1978. Fee: $75. Contact: *Norma Geddes, R.N., The Education Department, Ontario Crippled Children's Centre, 350 Rumsey Rd., Toronto, Ontario. M4G 1R8.*

Royal College Medical and Surgical Exposition to be held concurrently with the 47th Annual Meeting of the Royal College of Physicians and Surgeons of Canada. To be held at the Hotel Vancouver, Vancouver, B.C., Jan 25-27, 1978. Contact: *Royal College Medical and Surgical Exposition, 481 University Ave., Toronto, Ont., M5W IA7.*

Nursing Care of the Sick Newborn, a five-day conference to be held the week of January 30, 1978 at the Hospital for Sick Children, Toronto. Fee: $80. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G IX8.*

Hypertension Symposium to be held on Jan. 20, 1978 in Saskatoon. Contact: *Dr. U.K. Bhalerao, Saskatoon City Hospital, Saskatoon, Sask., S7K 0N7.*

Current Practices in Breast Feeding and Maternal Infant Bonding to be presented in Winnipeg on Jan 27, 1978. Fee $10. Contact: *Norma Buchan, Women's Centre, Health Sciences Centre, 700 William Ave., Winnipeg, Man., R3E 0Z3.*

February

Toronto Area Interest Group of the Orthopedic Nurses Association Two-Day Meeting to be held at the Hotel Toronto, in Toronto, Ontario on Feb. 9-10, 1978. Contact: *Marion Marshall, Chairman, Publicity Committee, 35 Front Street, Apt. 310, Mississauga, Ont., L5H 2C6.*

March

Sensitivity — An Integral Part of Pediatric Nursing. A one-day conference to be held on Feb. 22 and on March 1, 1978. Fee: $20. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G IX8.*

April

Patient Teaching Programs. A one-day conference to be held at The Hospital for Sick Children, Toronto on April 19 and on April 26, 1978. Fee: $20. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G 1X8.*

National Drug Abuse Conference to be held April 3-8, 1978 in the Olympic Hotel, Seattle, Washington. Contact: *NDAC '78, 200 Broadway, Seattle, Washington, 98122.*

CNA MEMBERS AND ASSOCIATION MEMBERS

CNA members and association members are invited to submit resolutions for presentation at the Annual Meeting and Convention, June 1978.

Resolutions must be signed by a CNA member and forwarded to the Resolutions Committee, CNA House **by 31 March 1978.**

Resolutions received **after 31 March 1978** cannot be presented to the annual meeting.

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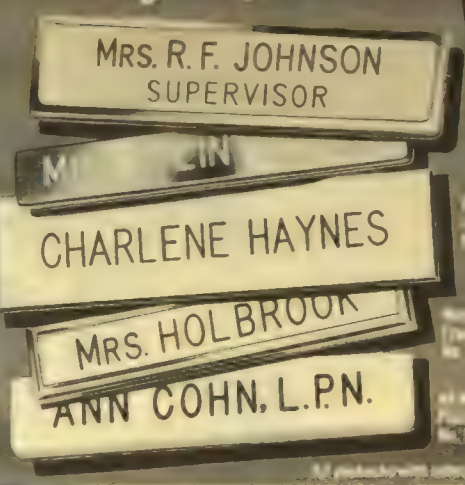
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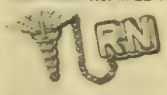
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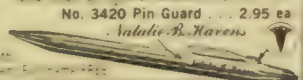
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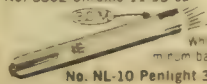


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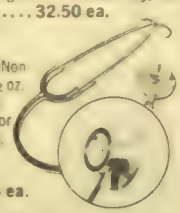
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FOUR SCORE AND TEN

Many professional women experienced the hardships of Army service during World War 1. At the close of the war there were 1,901 Canadian Nursing Sisters in the Army overseas. Nursing service abroad was far from being a "picnic" or a "joyride." Of those who went overseas, 53 are listed in the Memorial at Ottawa as having given their lives in the Great War.

This is the story of one of the women who served Canada so faithfully during the years 1914 to 1918. This is the second chapter in the continuing story of Maude Wilkinson.







"The following recollections are not written with any underlying thoughts of resentment or self pity. My memories of Army service are very dear to me and I consider myself most fortunate to have been able to serve my country in her time of need. All of the events of those years have remained very vivid in my mind — I have enjoyed relating them."

Maude Wilkinson



Nursing Sister
C.A.M.C



Once we were on board the train in Toronto the officers were directed to the first car, nursing sisters to the second and all other personnel followed. There was great merriment and laughter in our car as friends greeted each other warmly. Many parcels and gifts from family and friends left behind were unpacked. There seemed to be almost no end to the boxes of candy and fresh fruit. Newspapers and paper backed books were scattered everywhere.

While all this was going on other nurses sat quietly at their windows, gazing out at old landmarks. These were the buildings and places they had known for so long — no doubt some of them were wondering if they had made the right decision in leaving the positions they had attained, their comfortable homes, their friends and family.

We arrived at the docks in Montreal sometime after nine o'clock. Our orders were to prepare to leave the train and board a troop ship to cross the Atlantic.

It had been a tiring trip; a long exhausting day, both physically and emotionally. We were all assigned cabins on the ship. All of the cabins had four beds in them — bunk beds. We found our steamer trunks under our bunks with our canvas bags. It was terribly crowded; four women with haversacks and coat pockets filled with parcels took up a lot of room. There was no place to sit down, except on the bunks, and no room to dress or to hang our greatcoats.

I don't remember there being any discussion as to which bunk we would have. We were just too weary to do anything but stumble in and settle down for a good night's sleep.

Pandemonium and chaos reigned supreme in our cabin early the next morning. To be late for a meal was a serious offence and it was almost time for breakfast. The four of us decided that the two nurses on the top bunks should dress first. Hairpins and nets, toothpaste and brushes were soon lost on the floor with all of our luggage.

On top of this, time was passing quickly and the women in the lower berths had to get dressed too. But where could the ones from the top go? They could hardly climb up again.

It was a trying and embarrassing experience for all of us, one whioh we were all sure no male honorary lieutenant would have been subject to. But, at last, the four of us were ready and we made our way to the dining area.

Our cabin was near the small serving pantry by the saloon. We could smell the coffee, toast and frying bacon and it made us realize just how hungry we were. In spite of this, we waited, and waited, and waited.

I am sure the doctors were unaware of the fact that the more coffee they drank, the more cigarettes they smoked and the more amusing tales they told (some of which must have been very funny, judging from the laughter) — the longer we had to wait. The doctors in our unit were usually very kind and considerate of the nursing sisters and I know they were never informed of the situation because it was often repeated. But, "All's well that ends well," and in the end we really enjoyed that first breakfast.

A cautious crossing

We were all summoned to the upper deck after breakfast. Here we met with the captain and his crew. They gave each of us a life preserver which we were to carry with us at all times. We were also allotted space in a lifeboat, supplied with the number of the boat and the station to which we should report in the case of an emergency. Lifeboat drill was carried out each morning; we were entering the War Zone.

I don't think any of us had realized just how dangerous this crossing was to be. It was not until our ship had set sail that we learned a troop ship had been torpedoed near the Canadian shore. It was absolutely essential that we observe all regulations, not only for our

My niece Frances at ten months



Leaving CNE Grounds -1915

own safety but for the safety of all on board. The nights were the worst; all portholes had to be closed and darkened and there was no smoking allowed on deck.

Before long the sea became very rough, the air cold and windy. Matron soon retired to her cabin, many nurses were seasick.

The doctors tried to persuade us to walk and exercise but this too was very difficult.

At night, those who wished could remain dressed and sit out on deck. Very often I was one of the bundled figures in the darkness, clutching the few personal possessions that I had with me, fingering from time to time the little leather coin container with the five-dollar gold pieces that hung around my neck. (Someone at home thought that the gold would ensure my safety if I was captured).

England 1915

It took twelve long days and nights to cross the Atlantic. Finally, land was sighted and we prepared to disembark. The arrival of the Canadian nursing sisters created quite a stir at Portsmouth. Matron arrived on deck (looking quite rested) and told us to line up as we had been instructed by the sergeant in Toronto. We had to walk through the town to the train station and after our long sea voyage we certainly did not look our best.

One of the nurses who had a very deep voice was detailed to keep us in line. As we marched ahead of her "left, right left, right" soon attracted the townspeople. There we were clad in greatcoats, with haversacks slung over our shoulders and hats worn at a rakish angle; the English people no doubt wondered what on earth had landed at their sophisticated port.

One lady joined our procession at the rear, declaring as she fell in line that she too belonged to the Salvation Army and welcomed her sisters from Canada. To our wonder and relief she refrained from bursting into "Onward Christian Soldiers." Wherever we went in England or on the Continent, our uniforms, especially the two pips on the shoulder straps, awakened curiosity and amusement.

What a relief it was to be on the train and traveling comfortably through the lovely green countryside. The weather was just beautiful and we glimpsed many little cottages with thatched roofs as we sped through village after village. All the cottages seemed to have small gardens in the front, gardens (no doubt gay with summer flowers in peacetime) now planted with life-sustaining vegetables. We saw only old men and women whenever the train stopped at stations along the way. The only young people in evidence were the disabled or wounded; the able men were in the army and the women in munitions factories.

It was late at night when we arrived in London. Matron-in-chief, Margaret Macdonald, was there to meet us and direct us to one of the two old established hotels that were reserved for us. The next morning Miss Macdonald really endeared herself to us when she told our Matron we were to go to specified shops to have our dresses and coats shortened and our hats (so unbecoming) reblocked. She too must have been appalled at our appearance when we arrived.

We were allowed a few days leave. I had been to London before and I was very anxious to revisit some of my favorite 'old haunts.' But it was wartime now and I could not help but be appalled by the many changes. There were notices pointing to air raid shelters, fences and barricades around partially demolished buildings. There was rubble everywhere. The beautiful parks, where nursemaids, in their long blue capes and little bonnets used to sit and watch children romp and play, were now deserted and neglected. The whole city was so lonely and sad.

We were all disappointed when we found out that our hospital was not yet ready. The only thing that anyone could (would) tell us was that we would be going to the Mediterranean, eventually — just when or where no one seemed to know.

In the meantime, we were sent to the Canadian Military Hospital at Shorncliffe near Folkestone. Some nurses remained there; others were sent to Canadian and British hospitals in England or abroad.

Life was restful and relaxing at Shorncliffe. Our duty was light and our safety was assured. It seems that sometime early in 1914 a German plane had been shot down off the coast near Folkestone. Lifeboats had gone out and rescued the pilot and his crew. Although the Germans were officially prisoners they had received consideration and were treated with justice. Apparently, German headquarters heard of this and informed the Folkestone Council that the area would never, knowingly, be bombed — to the best of my knowledge it never was.

Before very long the four of us who had shared the same cabin while crossing the Atlantic (our nickname was "the Odds and Ends") were sent to a British hospital at Boulogne, France. I don't remember anything about our departure, crossing the channel or the train trip but I do remember the unenthusiastic welcome we received when we arrived on June 15th. The Matron met us and promptly told us she did not understand why we had been sent; she had not asked for, nor did she require additional staff. It was most disheartening. The following morning we lined up for breakfast at 7 o'clock. Matron was there and she asked for our ration books and handed each of us a tin pie plate, enamel mug and cutlery. Food was scarce in Boulogne but I never heard any of the British staff complain about it. I must confess that we Canadians felt it was quite inadequate after being spoiled at Shorncliffe.

It was interesting to observe the routine carried out in British Military Hospitals as compared with what we were used to. The orderlies gave most of the bedside care while the general nursing staff took temperatures, gave out the medicines and supervised the patients' nourishment. The sister-in-charge (the one with the little red cape) kept the records, made rounds with the doctors and was responsible for carrying out their orders. We were told that this system of patient care was followed in every British Military Hospital.

Matron supervised our work closely but we were only criticized if we tried to usurp the orderlies' duties. The British sisters were very kind to us. In fact, we were almost sorry to



leave on July 25th when our orders came to return to England.

Matron arranged our transportation to the station, returned our ration books and thanked us. We were given our rations for the return journey; a package of hardtack biscuits and a tin of bully beef! The station master put us in a compartment, locked us in and departed. We soon found that there was no other door except the one we had entered by, no aisle, no sanitary conveniences and no drinking water. We were not allowed out when the train stopped at stations for refueling.

So there we were, four graduate nurses, who before the war had held responsible positions, and enjoyed comfortable accommodation. I think it was our dignified Johns Hopkins graduate, who put one of our steamer rugs across the end of the compartment and thereby gave us a little privacy. The bully beef tin was opened, the meat carefully wrapped and the empty tin (a treasured possession) did valiant active service. The night dragged on endlessly.

Early the next morning, while the train was refueling, we saw two French Red Cross volunteers peering in our window. By sticking out our dry tongues and clutching our throats we were able to convey the fact that we were parched for something to drink. They looked at one another and seemed to understand what we needed for one of them ran off somewhere. She returned with two bottles of cider which she thrust into our hands just as the train started to pull away.

You can imagine our relief. We had had nothing to drink for twenty-four hours; the salt in the bully beef and the dryness of the hardtack worked together to create a terrible thirst. The cider, which we drank from the bottle, was cool and refreshing and it soon disappeared. The four of us, ex-matrons and senior supervisors became merry, in fact, very merry and a little inebriated. What a scene for a movie! To top it all off when we crossed the channel we found that bully beef, hardtack and cider do not mix very well. All of us were very sick.

The train from Dover to London seemed quite luxurious in comparison to our journey through France. We were rested and relaxed by the time we had lunched in London and continued our journey to Shorncliffe. There we told our friends all about our experience on the train in France and we were able to appreciate their amusement.

We were stationed at Shorncliffe until October 18th. The wards were not filled and once again our duty was very light. The weather was warm in the daytime and the nights were beautifully cool.

Moving to the Mediterranean

Rumors about our departure ran rampant but it was autumn before we received our orders to move out. We heard the doctors and men of our unit (those who had not been retained at Shorncliffe) had sailed on a troop ship for some unknown destination. Soon the rest of us were off to Tilbury docks to board the Kildonan Castle, an old passenger ship converted to carry troops. They told us that we were bound for the Mediterranean. It had been five months since we left Canada and yet we were still unaware of the location of our hospital.

Life on the Kildonan was very different from our Atlantic crossing. The four of us had comfortable two-berth cabins and plenty of deck for exercise, shuffleboard and games. Still there was the constant threat that we might hit a mine or a submerged iceberg. I never felt that we could relax and "breathe easy."

Finally, our ship left the Atlantic and entered the Mediterranean Sea; now the weather was warm and the sea calm. We sailed from island to island taking troops and cargo back and forth. We began to wonder if we would ever see land, surely our hospital





Off duty



Nurses' dining room

was ready now!

We had thought we would disembark at Malta but instead we left the Mediterranean and via the Aegean Sea entered the Dardanelles. At Suvla Bay, Gallipoli,Turkey, orders were received to transfer the nurses to a hospital ship where sick and wounded were waiting. British sisters had been expected but their arrival was delayed.

We found the patients very ill, suffering from malaria, typhoid, malnutrition and black water fever. There were very few surgical cases.

This was our first contact with British military orderlies at sea. They took over completely, removed filthy uniforms, washed the patients and put them into cots. Each man's uniform was folded, tagged, tied and placed outside on deck. The uniforms were alive with vermin; I do not exaggerate, those bundles, out in the sun on deck actually moved as the vermin rose to the surface.

Directed by the orderlies we, as nurses, took temperatures, and gave medication and nourishment. I had appreciated the service of the orderlies while I was in Boulogne but out here, in the middle of the ocean and under very difficult circumstances, one could not help but admire their devotion to duty, their care and consideration of these helpless patients.

Eventually all of the patients were transferred to another hospital ship to return to England.

Matron decided that the nurses who had been ill (including herself) would remain behind recuperating. The rest of us (thirty-five nurses) stayed on board and went back to Suvla Bay to see if another trip was necessary. The decks of the ship were scrubbed, and chairs were placed outside for us; the return journey was most enjoyable. The British doctors and crew were very pleasant and most entertaining.

The British sisters still had not arrived and so the major asked for volunteers from among us to go further up the coast to a place he called 'Hill 60'. There were men on the hill who had been exposed to enemy bombardment and they had to be rescued. Eight of us



Loading an ambulance train



Nurses' quarters



volunteered. We arrived at the "rock" and cast anchor in the darkness. The crew started bringing the patients on board as we looked down at the sick bay.

I had never seen such emaciated human beings as those they carried aboard that night. Even the men who were able to walk were just skeletons. We learned these men had been left on this hill to be picked up later but while there, they had been subjected to German gas shells and daily bombardment by enemy ships. All of them were suffering from dysentry and malnutrition. As they were brought on board the orderlies took off their filthy ragged uniforms, wrapped them in blankets and placed them in hammocks. At first the major refused to let us go down to the sick bay and this caused considerable argument.

Eight determined women insisted they were on active service to serve and serve they would. Finally he allowed four of us to go down for ten minutes, to be relieved by the other four. This was how we passed the entire night. The air in the sick bay was foul, one could hardly breathe. Other than offering the men a spoonful or two of warm liquid there was really little anyone could do for them. Those who were able, looked up, smiled and said, "Thank you, sister." It was hard to fight the tears back.

Every few minutes the engines would slow down. The patients knew what this meant; another lifeless body, wrapped in a blanket, was lowered to his watery grave. The Union Jack covered the body but as it descended into the water the flag was hauled back, ready for the next time.

Later in the day we transferred our patients to a hospital ship that was bound for England and we went back to Suvla Bay. I never found out how many of our patients died or how many were able to continue their journey — it was a very helpless feeling.

In the meantime the British sisters had arrived at Suvla Bay and so we changed to another ship and sailed to Malta. From there we moved on to Salonica (now Thessaloniki) Greece, — our hospital site.

Building our own hospital

We were taken out to our camp the minute we arrived at Salonica. Our doctors and all the other men had arrived a few days earlier. Before they had even a chance to unpack their personal belongings a convoy of sick and wounded from a Casualty Clearing Station up north, had arrived. There were no hospital tents ready, no cots unpacked and the doctors had to tend to patients who were wrapped in blankets lying on the ground.

The next day they received word that a second convoy was to be expected. When we arrived the doctors were hastily putting up tents and unpacking cots, mattresses, blankets and pillows. We quickly discarded our coats and luggage and worked with them. As each tent was pegged down, cots were placed in them (20 to a tent as ordered by the quartermaster). We made the beds and used packing crates to serve as bedside tables. It was really thrilling to be assisting in the establishment of our own hospital. We worked side-by-side with the doctors of our unit, many of whom we knew by reputation as professors and deans of medicine in various Canadian universities.

Early in the morning of our second day , I was working in one of the tents carrying a load of bed linen. I heard a voice behind me saying, "That bundle is about as big as you, here, let me help." I turned and looked up to a tall man who was smiling down at me. I thanked him and we worked together all morning.

Everyone was helping each other, no introduction was necessary and there was no exchange of names. It was at lunch that I heard one of the doctors call him by name and I realized he was a very well known surgeon in Toronto. He appeared each morning and I was very thankful for his help. In this informal way a friendship started and lasted all the time we were overseas. 'My friend' as I have referred to him in these memoirs remained a sincere and loyal companion.

All of the staff was assigned wards and living quarters. I was to work in a medical ward which was directed by a Toronto doctor whom I had known and greatly respected at home. One or two medical students assisted the doctors on the wards. I loved ward duty and was content and happy.

We were very busy organizing and settling the tents. Each ward was made up of three 20-bed tents placed end-to-end. Beds were pushed to the sides so that an aisle formed down the center. The whole thing looked like a 60-bed ward with 30 beds on each side.

The main entrance was in the first tent where we arranged some space for the nurses' station. The beds in this tent were reserved for very sick patients.

Coffee, sugar and extra cans of milk were available if charge nurses wanted to make morning coffee for the doctors and themselves. I was glad to do this and found that I really enjoyed the custom. After the first few mornings the doctor on my ward asked if it would be possible for me to make a larger quantity of coffee, he would like to have three of his friends join him. He said he would provide the extra coffee. The next morning his three friends arrived; the former Dean of Medicine at the University of Toronto, the chief of Obstetrics and Gynecology of the largest hospital in Toronto (an attractive Scotsman and a bachelor) and 'my friend'. They were a congenial group and they really enjoyed being together. I usually left the doctors alone after serving their coffee; there was always something to see to on the ward.

Conditions at Salonica

At first everyone thought our camp had an ideal location. We were six miles from the town of Salonica, on the Aegean Sea and there was a good road nearby for getting supplies from town. By the end of November we realized that everything was not as rosy as we had thought. The weather became cold, rainy, windy and very wet. Walking was difficult because there was so much mud. We decided that when the permanent huts were built in the spring they should be located on higher ground.

My tentmates and I,(the Odds and Ends) almost hated to think of leaving our tent which we had arranged so comfortably. Nurses lived in large square Indian tents; there was ample room for each of us to have a corner for our cots, a dresser (two packing crates), a wash stand, a stool and a trunk. Our quartermaster and his staff went into town to get supplies every day. We asked him to buy us several bright Indian cotton bed spreads. We used one



Officers ward

spread each to cover our beds and hung the rest of them on wires around the corners. This gave us all some measure of privacy and the total effect was really very pretty.

Our tents had no floors so, even although rush mats had been provided, they were soaking wet each morning. We hung the mats up during the day but they never really had time to dry out.

Water for drinking and washing was rationed; a quart to each person daily. As tenmates we decided to put some aside each day for our evening 'cup-o'-tea'. The quartermaster supplied us with a primus stove, a small kettle and four mugs. It was truly a gala occasion when one of us received some cookies or fruitcake from home. The four of us were very happy together and our evenings never seemed to lag.

Christmas 1915

One week before Christmas we were told the boat from Canada which was bringing our personal gifts and decorations for the trees and tables would not arrive on time. The rumor was that the boat had been torpedoed.

Each ward was expected to make their line look festive using only the material we had on hand. Both patients and staff worked feverishly and soon wonderfully wrought paper chains appeared. They were made of looped rings of red blotting paper, the blue tissue from absorbent cotton rolls and white shelf paper. The chains were strung from the center of the roof of each tent to the four corners. Large colored paper letters were pasted on the walls wishing everyone a Merry Christmas. The decorating caused a good natured rivalry between wards.—Whose ward would be the most attractive?

Traditionally the V.D. wards in all British hospitals were manned by trained medical orderlies, under the supervision of a doctor. Nursing sisters were not usually assigned to these wards but this was not so in our hospital. One of our most respected senior nurses, my tentmate the Johns Hopkins graduate, was put in charge. We felt that this was an international slight but with her good sense of humor this woman just smiled. She always spoke well of the poor lads who were so far from home and so lonely. She knew they had yielded to one of the evils of war but she didn't think anyone should punish them by denying them good nursing care. The men respected her and appreciated her acts of kindness.

When she entered her ward on Christmas morning the first thing she saw was a red blanket hung on one side of the tent — "God bless our Sister — Merry Christmas." The letters were made of absorbent cotton and pasted on the blanket. My friend was very touched — it was a tribute to a great woman.

Just where our quartermaster found enough fowl and vegetables to feed all of our patients, employees and staff we never knew. There was wine and beer for those who wished it. Bedside tables placed end-to-end provided dining tables for up-patients on the wards. When we covered these tables with white sheets and decorated them with boughs of evergreen they became very attractive. After dinner everyone able went to the assembly tent for the Christmas concert. It was a wonderful opportunity for some of the men to display their talents in both verse and song. After it was all over we couldn't help but wonder if things could have been better even if the ship from home had arrived.

Early Christmas morning we nurses discovered cards covering the ground outside our tents. The French flying officers often had tea with us in our mess. They seemed to enjoy the hospitality and were very amused at our efforts to talk to them (not many of us spoke French). The cards were printed in English and wished the Canadian nursing sisters a "Very Happy Christmas". They also added that we would never know to what extent the sight of our willowy frames broke the monotony of their ceaseless nightly vigil, as they patrolled the sky over our camp.

Our officers were very amused and never missed an opportunity to remind us of our obligation to "break that monotony."

Night Duty

Our coffee hour was particularly merry on the morning after the New Year's Eve Masquerade. The doctors were joking among themselves and the patients (and myself) were really enjoying hearing about the "dress-up" affair. I was just pouring the coffee and sharing in the light-hearted conversation when Matron walked in. Her disapproval was most evident.

I was called to her office later in the morning and told that our practice of a "coffee hour" was to be discontinued. I tried to explain to her that my doctor had asked me to do this and I felt that if she wished the practice discontinued she should talk to him about it. I was promptly assigned night duty, — much to my doctor's annoyance and my friend's amusement. The coffee hour was continued by the nurse who relieved me.

I did not look upon night duty as a hardship. During the cold winter weather, the little oil stove kept the office cozy and warm. The very sick patients usually slept quietly close at hand and there were two orderlies to help with rounds. It was actually very peaceful compared with the hustle and bustle of day shift. Night duty also allowed time for me to talk to the patients, to listen to their news from home and to do little extras for the bed patients.

'My friend' asked me if I disliked night shift. I had to confess that I was afraid of falling asleep after returning from the 11 o'clock supper break. I usually took some sewing, plenty of notepaper and some light reading with me but some nights it was very difficult to keep from 'nodding.'

'My friend' said he would remedy this situation. From that night on he arrived promptly at 11:30 each night with a book or some trifle he had picked up tucked under his arm. One night I picked up a paper backed book I had found. "Why," he asked,"do you waste your time reading such trash? I'll bring you something more worthwhile." True to his word he arrived the next night with a couple of little books; classics he liked and carried with him. I must confess I never told him that he was only adding to my misery. The books would be beyond my comprehension in the daytime. In the middle of the night they proved to be a most potent sleeping drug.

Days and sick leave

My term of night duty ended and I returned to my ward. The up-patients came to me almost at once begging for some odd jobs. Some of them thought that if they made themselves indispensable around the hospital their transfer back to the lines might be



postponed. Who could blame them for feeling this way when we knew all of the hardships they had endured and the circumstances which they faced on the front?

Our medical officer was most considerate and understanding but at the same time he knew he had to discharge them when they were physically fit. It was always hard to see our recovered patients off.

Although there was little serious sickness among the staff of our unit, nurses were beginning to show the strain of the intensely cold winter and the hardship of their experiences. The medical officers suggested some of us should be sent to Malta on sick leave. I thought I had been very well except for a bout of rheumatic fever and malaria that kept me in the nurses' sick tent for a couple of weeks. I was sent with the first group to a rest home in Malta.

It was wonderful to be able to relax and be cared for. It also gave me an opportunity to think seriously about the future — my future. We had been told that our unit would be leaving Salonica early in 1917 and would be re-established in England. I did not want what we considered 'home service'. I wanted to go to France on active duty. I also wanted to have one trip to Canada on transport duty if possible. I returned to Salonica with renewed energy and a planned future.

Our Johns Hopkins graduate and a young Sick Children's graduate were not as fortunate as I was. They had been very ill with typhoid fever in September of 1916 and it was decided they should go home. They both survived the trip, recovered and were on hand to greet us when we returned to Canada.

My first assignment, when I returned to Salonica from sick leave, was to the pantry in the officers' and men's ward.

The general kitchen staff did not have time to prepare any spiced foods or dietary niceties. The sick officers were given the same general rations as the men on the other wards and it was up to the nurse in the pantry to use this 'plain' food and serve it more temptingly. It was quite a challenge but I had always liked puttering around the kitchen at home.





Surgical ward

"Soup! Sister we haven't had any for weeks, where did you get it?" (a few oxo cubes dissolved in the vegetable juice, the vegetables, a wee bit of curry and butter. I thickened it a little and served it hot with croutons).

"Say sister, that meat roll was wonderful how did you manage it?" (the meat ration, chopped fine, a beaten egg, a little onion, seasoned and rolled in the rationed mashed potato, served hot).

Most of the nurses hated this job and we were not kept in the kitchen for very long but I really enjoyed it. I left determined to prepare little extras for the sick on my own ward.

It was my turn for night shift again. The weather was getting very warm and I was glad to be able to sit outside late at night feeling the cool air from the sea. I wish I could describe the beauty of the moonlight shining on the snowcapped peak of Mount Olympus, the sky ablaze with stars.

I was still on night duty when we moved into our "permanent" huts in the spring. Although as many patients as possible had been sent to other hospitals in the district the move caused quite an upheaval. All of the staff packed their personal belongings (which seemed to have increased tremendously since we had arrived) and the quartermaster and his staff transported everything to designated huts. Miss Ferguson and I were assigned a two-bedroom hut, our other two tentmates were next door. Although we missed the homey atmosphere of our tent it was nice to have a proper floor under our feet and a window to open and shut. The bath house, which served all the nurses in the compound, had cold water (no hot), bathtubs, showers and toilets with septic tanks.

The new huts made our work on the wards so much easier. We still had 60 patients in each ward but now they were all in one building with 'built-in' washrooms.

We stayed in Salonica until early in July 1917. Then our unit returned to England and was established at Basingstoke, Hampshire County.

Back to England, 1917

In many respects I was sorry I had decided to leave my unit. But I knew life in England would be very different and I was sure that wasn't what I wanted right away. Four other nurses had applied for transport duty and I decided to send in my application too. Our orders came through in July and we left Salonica on the Saxonia, a hospital ship, bound for a southerly port in Italy. There we boarded a train for Calais.

When we arrived in London we went directly to headquarters to report to Miss Macdonald and to find out when we would leave for Canada. She could tell us only that there was a long waiting list for transport duty and we might have to wait until October. In the meantime she sent us to nearby hospitals. I went to Taplow in Buckinghamshire to the No. 3 Canadian Hospital based on Lord Astor's estate Cliveden. Life there was very different

as compared to active service in the Mediterranean. The nurses' uniforms looked almost new, their bibs and aprons were starched and pleated, even their veils looked different. I felt very shabby in my faded blue and greyish apron. The atmosphere at tea-time was very 'social'; conversation was gay and bright with the latest hit song and movie in London being the major topic of discussion.

By this time my unit had arrived at Basingstoke and 'my friend' contacted me at once. We were both about an hour and a half from London and so we decided to meet there on my free afternoon. In London I ordered some new uniforms and aprons and then we went to a café for tea. We had dinner together later. My train left around nine so I was back in plenty of time for curfew.

I told 'my friend' that I was stationed at Taplow until transportation was available and it might be October before I left for Canada. We planned to meet each week on my afternoon off.

An audience with the King

Every month, weather permitting, a group of patients from Taplow were taken sightseeing. A doctor and nurse accompanied them. Most of the staff hated these exercises but the patients loved them. I was detailed to visit Windsor Castle. The medical officer accompanying me looked bored to death right from the start.

Upon our arrival at the castle we noticed the Royal Standard was flying. We were informed Their Majesties were in residence and would receive us. The medical officer certainly came to life quickly. He inspected each man; ties were straightened, caps adjusted. I found a pair of white gloves and we proceeded to the state room. King George V and Queen Mary received us. They were most gracious, inquiring about Cliveden and our work there. They shook hands with all of the men and asked them about their service. Tea was served downstairs after the reception. Princes, Edward, Albert, Henry and Frederick there. The Princess served us with a smile while she made polite conversation. The Princes, Edward, Albert, Henry and Frederick stood grouped together in a corner looking bored to death — they must have done this so many times before.

Finally my orders for transport duty came through. There was a permanent staff in the sick bay on the boat so, as temporary staff, I just assisted. Some of the patients were very ill and would probably be bedridden for the rest of their lives. Others were jubilant — they were going home, at last. My duties were light and the voyage was uneventful.

I wired home from Halifax just as soon as we docked. I was allowed only seventeen days shore leave and I could hardly wait to get home. It was wonderful to be with my family and friends again. They certainly spoiled me (and I certainly enjoyed being spoiled). Time passed all too quickly.

Special duty

I returned to Taplow and was there for Christmas. Eary one January morning I received word to report to Miss Macdonald's office in London immediately. Naturally I was worried, what in the world had occasioned such an abrupt summons? My alarm was unfounded. Miss Macdonald called me only to put me on night duty with a repreentative from the Canadian government who was ill in a London hotel.

I found my patient irritable and demanding. He was "suffering" from a mild attack of influenza. He was critical of everything; the food, the hotel service, his medical doctor, but most of all, the weather. In my heart I found it very difficult to be sympathetic with him, especially when I compared his comfortable suite with the terrible conditions under which the troops lived and the great hardships that they faced every day.

In spite of this I could not blame my patient when he dreaded nightfall. As soon as it was dark, the bombing started. The hotel was located in the center of the city, near the building the enemy was trying to demolish. My patient asked me to stand by his bed. I did but I couldn't help but wonder what he thought I could do if the hotel was hit. I disliked the whole ordeal as much as my patient did and was very relieved when the doctor said that he was well enough to go home.

Matron said I was due for leave. First I left to visit relatives in Hessel, then I returned to London to visit with 'my friend.'

I stayed in a real Victorian guest home while I was in London. A maid brought me tea in the morning, lit the small grate and then reappeared later with a brass jug of hot water.

'My friend' arrived from Basingstoke each day on the noon train. We would have lunch, tea and dinner together before he returned to his station at night. Something made us realize that this was the end of a happy relationship which we had both enjoyed. We had spent some pleasant afternoons together over the last few months — these days were really our farewell reunions. I was going to France and would probably be there until the end of the war, he would stay with the unit at Basingstoke.

I have hesitated introducing this personal situation into these memoirs since it does not relate specifically to my nursing service but I feel I owe so much to this man's friendship and guidance that I could not help but include him. Without his advice and counsel I may not have been able to undertake some of the unusual responsibilities placed on me during those war years.



My tent mate: Miss Ferguson



Nurses dugout



Armistice and home

The routine followed at the hospital I was sent to in France was similar to that carried out at all British military hospitals. The orderlies gave most of the bedside care, the sisters spent most of their time with the patients.

Oddly enough, it was difficult to make our patients understand the war was over once Armistice was declared. Each of them reacted individually. Some were overjoyed at the thought of home and reunion with their families. Some were afraid they would not survive the long journey, hoping and praying transportation would be available soon before their condition got worse. But others, and these were the most pathetic, realized it was too late ... they would never be able to leave.

I was sitting with a patient one night. Both of us knew his time had come, he would not live through the night. I thought he had slipped into a coma but he murmured to me, "Sister, would you give me my wife's picture, it's in my haversack." I put the picture in his hand, he lay quietly for a while and then slipped away. I wrote to his wife later that day and told her he had died peacefully and of his request to have her picture. Things like that happened so often through those years and yet they never failed to leave me feeling sad and empty.

Christmas was not very festive that year. Most of our patients resented the long delay in transportation home; the evacuation proceeded very slowly. I was to return to England on January 25th, 1919. I was glad that I had been in Boulogne during those last months. A close relationship developed between patients and staff — the sort of relationship we associate with a patient and his family doctor in Canada, an understanding and respect for each other. I had never experienced a feeling like this before.

I returned to London and stayed in an officers' convalescent home until I was notified transportation home was available. For some reason I did not let 'my friend' know that I had returned from Boulogne. When I arrived at the docks I learned that my unit had sailed without me for Canada the day before.

When I arrived in Halifax I bought a morning paper and boarded the train for Toronto. On the front page there was a picture of 'my friend', a prominent Toronto surgeon who had died suddenly at sea. Respected and honored at home and on active service, he was a great scholar and a gentleman. I could not help but mourn his death.

The long train trip from Halifax to Toronto gave me an opportunity to think about and plan for the future. I would not be officially discharged until May ... where would I go then? What would I do?



Body image and the crisis of enterostomy

Every one of us grows up with a body image — a unique way of picturing our physical selves. What happens when this image is suddenly disturbed by a radical change in our bodies? Enterostomy surgery often poses a serious threat to an individual's body image and self-concept. The following article shows us how two patients reacted to the crisis of enterostomy.

Sandra Lindensmith

Each person has a mental picture of his physical self — he may think of himself as tall or short, fat or thin, beautiful or homely, or somewhere in-between. He has spent years learning to live with his body image. The picture he has of himself affects how he feels about himself as a person, and consequently how he interacts with others.

Adjustment to any change that causes an individual to perceive himself in a different way may be difficult to make. Think of a friend who has lost a great deal of weight in a short period of time. You may notice that he is thrown completely off guard when others do not respond to him in the accustomed way, but instead comment on how great he looks. Inside, he may still feel like a "fat" person; he may even respond to unfamiliar compliments in a negative way.

As nurses, we come into contact with those who undergo more radical physical changes; illness itself alters a person's body image. But when a person has an amputation, enterostomy, or mastectomy, the sudden change may be more than he can cope with, because his perception of himself as a whole person is altered. Not "himself" any longer, he may feel threatened in his interactions with those who have been very close to him. It is important for us to recognize that these types of surgery can pose integration problems for the individual, problems as serious as any other complications of surgery.

Body image has been defined as "the constantly changing total of conscious and unconscious information, feelings and perceptions about one's body in space as different and apart from all others. It is a social creation developed through the reflected perceptions about the surface's of one's body ... The body image is basic to identity ..."[1]

A dynamic concept

As a dynamic concept, body image is subject to change in response to the aging process itself. For most healthy adults, the body image boundary ends at the body wall.[2]

At birth, the infant has no notion of his body as separate from the rest of the world. The infant's discovery of his body through sensory experiences and sensations marks the beginning of the growth process. His body image becomes part of his identity.

Freud's psychoanalytic theory notes three stages of early development: oral, anal, and genital. According to this theory, a child must master each of these stages as he grows up in order to develop a mature body image. If he cannot integrate the function of each of these areas into his total body picture, his body image will retain some immature aspects.

In relation to this article, mastery of the anal stage and accompanying mastery of the body and environment and their control can be a factor in acceptance and emotional and physical mastery of an enterostomy.

Body image does not develop in a vacuum; it develops in response to the attitudes and emotional overtones that each individual experiences within a family or peer group. Other individuals have a strong influence because of their evaluations of an individual's body. Acceptance of an enterostomy may thus become very difficult for an individual who has been raised with the idea that bowel function is "dirty" and therefore a taboo subject.

A disturbance in body image can occur when a discrepancy develops between the way an individual has always pictured his body and the way he currently perceives it. This kind of conflict can produce anxiety and fears of being rejected, feelings of being "less than

whole." Body image disturbances commonly occur with enterostomies, mastectomies, amputations, and pregnancy and can occur with any form of physical or emotional illness. Enterostomies require both the removal of an organ and removal of a form of bodily control; as such they can represent a two-fisted assault on the individual's body image.

Catherine M. Norris states that "Adaptation to alteration in body size, function or structure... depends upon the nature of the threat, its meaning to the individual, his coping ability, the response from others significant to him, and the help available to him in undergoing change and to his family."[3] It is important to keep in mind not only than an individual's image of his body influences his interactions with others but also that the responses of those he loves influence his ability to cope with a new body image.

For many middle-aged adults of today, the feelings of masculinity and femininity are strong. During their younger days, these two concepts and their differences were emphasized. Little girls looked like little ladies, were quiet, and refrained from wearing pants or playing rough games. Little boys were rewarded for "toughness," not crying, for being physically active, and for strength. The concepts of masculinity and feminity are integral components of the larger concept of body image.

So far we have looked at theories of body image. Now let's look at two patients of the same age with colostomies and at how the colostomy affected their feelings of masculinity and femininity. In discussing these two patients, Mrs. S. and Mr. C., three categories of the nursing process will be used: assessment (including data collection), intervention, and evaluation.

Mrs. S.

Assessment

Mrs. S. was a 53-year-old Caucasian woman who was treated for carcinoma of the colon with a transverse colostomy. Her postoperative recovery from surgery, except for an immediate period of nausea and vomiting, was described as uneventful.

Her physical status following surgery was good; although she described herself as "weak" and appeared to tire easily, her appetite was slowly beginning to improve. Except for her colostomy care (she refused, a week after surgery, to *look* at her colostomy), Mrs. S. attended to her own needs.

It was clear from Mrs. S.'s admission onwards that she was a woman who was very concerned with her appearance. On the day of her admission she had just come from the hairdresser, explaining, "I knew it would be a while before I had a chance to go again, and well, you know, it makes me feel like a lady." As soon as she had bounced back from the immediate effects of her surgery, she asked to see herself in a mirror, and was always concerned with being well-groomed and attractive.

Every day, before her husband's visit, she would "freshen up," and it was only a few days post-op that she asked to exchange the graceless hospital gown for a fresh nightgown of her own. Her behavior in this regard was not excessive; but it was readily apparent that being lady-like was important to her.

Mrs. S. was a pleasant and friendly woman, somewhat nervous, and very concerned about being "a nuisance." She was also a very busy woman and kept herself going with knitting and crocheting as soon after the operation as she could.

There was evidence from the beginning though, that the presence of the colostomy disturbed her deeply. After her surgery, she requested that the curtain between her roommate and herself remain completely closed, in spite of the fact that friendly conversation from both sides of the curtain was constant. Mrs. S. stayed out of sight of her roommate for some time; she took her exercise by walking around her bed many times a day, refusing to venture from behind the curtain, much less out into the corridor.

Dressing changes left her visibly shaken. She refused to look at her colostomy, staring up at the ceiling or out the window with tears in her eyes, and remaining unusually silent. She would say after the dressing was completed, "I know I'm being silly, but I can't look at it, not yet."

At the same time, she seemed to recognize her own need to come to grips with her situation, to realize that her limitations were of a temporary nature, to know that she only needed time. "Right now I'm being a baby, but you'll see — one of these days it won't seem so bad to me and I'll be looking after it myself, not bothering you."

During the first week, her visits with her husband were controlled, and they talked for the most part about what was happening at home, or outside. This was something she also seemed to understand, "It's hard for me to talk about it, with anybody, and that means Bob, too, right now. But I'll get there."

Intervention

My main concern for Mrs. S. was to show her positive support, gentle encouragement, and to let her know that I understood her need for time. Just talking with her and showing concern for her welfare seemed to help. Initially she would only refer to her colostomy obliquely, expressing instead concerns about her general welfare, her roommate's health, or how her husband was managing at home. She seemed satisfied that her prognosis, after surgery, was good.

Mrs. S.'s colostomy however, became something that was difficult for her to ignore, because of the number of changes necessary to keep her clean and dry. So much of my intervention revolved around its physical care. I tried to let her know that caring for her was not "a nuisance" to me, that my interest in her as a person involved all aspects of her care, and not just the "messes" as she referred to them. Because her colostomy care took a great deal of time and a little ingenuity, it was not too long before her curiosity got the best of her.

She took her steps slowly — initially, just by looking at the colostomy after I had cleaned her up one day. Her colostomy was large and edematous at first, but she said "not as bad as I had thought." When I brought her lunch tray that same day, Mrs. S. had opened the curtain that sealed her off from her roommate and the rest of the world.

A few days later, Mrs. S. was making direct references to the stoma and began, tentatively at first, to ask question about it and to take part in changing her appliance. Up until this time, she had left all care of the stoma to me, but once she began to participate, she learned very quickly to assess and solve any problems she had. She learned about her colostomy and its functions, and began to develop the technical skills needed to take care of the stoma.

It took a week for her to brave the halls of the hospital; she would not try until she felt secure that she didn't "smell" and wouldn't leak. Soon after that she had a daily visiting pattern worked out with other patients.

She also began to tell her husband all about the stoma, and how she looked after it, and the relaxed look on his face assured me that the controlled conversations behind the curtain had come to an end.

Evaluation

By the time of her discharge, Mrs. S. had made many friends on the hospital ward. Her interest in everything that went on around her assured me that she was well over the initial shock of having a colostomy. Her face was less guarded; she expressed great satisfaction and determination in being able to take care of herself; she initiated conversation about particular problems that she had in caring for stoma, the "thing" that she had formerly refused to acknowledge or even look at.

I felt that with Mrs. S., adjustment to a new body image was facilitated by her love of life and of people. Mr. S. was warmly supportive of his wife; he expressed his love for her openly; and it was evident from the way that he interacted with her that she would always be his beautiful wife, colostomy or not. Although he was distressed at her initial behavior, he was also very patient, and seemed confident that she would eventually be able to cope with her colostomy, and see her situation in perspective.

I feel that Mrs. S. was as honest in her adjustment as she was in her initial feelings of repugnance and consequent withdrawal. Immediately post-op, she was in obvious emotional distress, but given time, she could handle the change in her body image. Because of her interest in life, she could see the colostomy as a challenge rather than as an assault on her integrity as a person.

Mr. C.

Assessment

Mr. C. is a 53-year-old Caucasian male. On September 28, 1976 he was in a motor vehicle accident and as a result sustained multiple injuries — lacerated mesentery with bowel and terminal ileum infarction, separation of mesentery and ileum, active bleeding and pulmonary contusions. His treatment involved the surgical creation of a temporary loop colostomy; his sigmoid colon was brought up to the surface of the lower left abdominal quadrant.

When I met Mr. C., his physical status was fair to good. He had regained his bodily functions — urinary, digestive and bowel — following a normal postoperative course. His stoma was very red and edematous (three inch diameter, raised approximately three inches from his abdominal surface). An upper GI series had recently indicated the presence of a diaphragmatic tear and hiatus hernia; consequently a surgical repair was planned.

His emotional status regarding the colostomy was far from satisfactory. I felt that this was largely due to the fact that he had no preparation whatsoever before his surgery. After his accident he had awakened from anesthesia in a strange hospital with no family members nearby and with a large and unpleasant looking stoma. The situation was a complete shock to him.

Mr. C. was uncomfortable with the colostomy, unaware of its function or purpose, and reluctant to assume responsibility for its care. He used the words "it" or "thing" to refer to the stoma, and although efforts were made to make him aware of the proper term, he refused to refer to the stoma correctly. He appeared very upset at the thought that he was "not a man anymore" and repeated over and over "my wife will never see it."

The very thought of his colostomy threatened the way Mr.C. saw himself; he seemed to think of nothing else. He expressed considerable concern about the fact that his bowel function had become so visible. The colostomy seemed to touch his whole life. He worried about odor, expellation of flatus, leakage, the sight of the stoma, and his activity level. He was also concerned about his job, which entailed some manual labor and lifting.

It was as if Mr. C. felt that he was no longer himself; his masculinity was threatened. Consequently, he wanted as few people as possible to see the stoma (this included his wife), and wanted no one outside of the hospital staff to know about his operation, especially his co-workers. It was so important to him to be "one of the guys"; in his frame of mind, to return to work with a colostomy was impossible.

Mr. C. was adamant in his refusal to let his wife share the crisis with him and help him through it. From the very beginning, he told me that he would never consider the idea of having sexual relations with his wife or returning to work until "it" was gone. He said that any physical closeness with his wife would only make matters worse.

Intervention

I spent most of my time with Mr. C. in conversation, trying to help him accept the fact that he had a colostomy. I taught him about the way in which a colostomy functions and why he had had the surgery, reinforcing the teaching he had already had about appliance changes. I also explained the properties of his appliance — that it was an odor controlling and practically leak-proof bag. We talked about the correct technique for attaching the appliance, so that flatus could be expelled with little notice. We also discussed the practical limitations on his activities that the colostomy meant — I explained that in many areas he didn't need to limit himself.

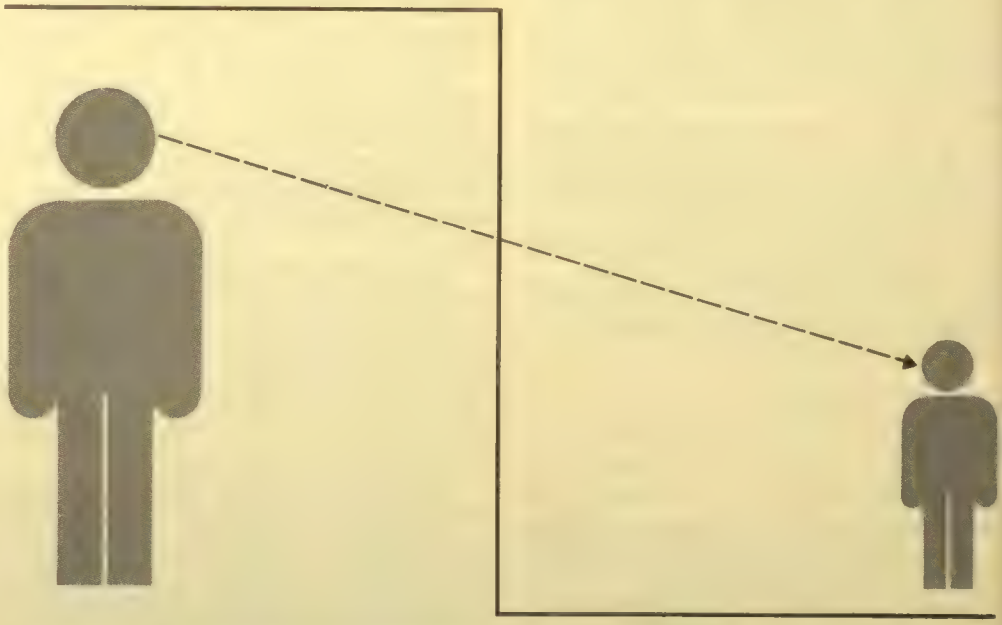
I tried to initiate open and honest discussion with Mr. C. For the most part he remained reticent and would not discuss his feelings or fears. He viewed himself as an "invalid" and a "baby" but did not want to discuss the matter further because he said it made him uncomfortable "just thinking about it." When I asked him why, his only reply was "It just does." He also remained very closed with his wife and children.

Mr. C. opened up a little during a conversation we had about the future closure of his colostomy. This discussion and a conversation we had following closure of his colostomy helped to explain some of Mr. C's feelings.

Evaluation

On the second day that I cared for Mr. C., he changed his own appliance. This seemed to me to be a positive step. When I asked him some basic questions about the functions of his colostomy, he was able to answer well. At least Mr. C. had a beginning knowledge about his colostomy. He appeared a little more relaxed as we talked about odor and leakage. As I watched him attach the appliance, he pressed all the air out of it to allow for any flatus.

However, from our talks about closure and following closure, it was apparent to me that he had never accepted the colostomy. He consistently refused to refer to his stoma as anything but "it." When I saw him after the stoma was closed, the first thing he said to me was "It's gone. I'm me again." There was relief and happiness written all over him. He also told me about his situation at home while he had been waiting for closure.



Mr. C. had refused to show his family the stoma, nor did he ever discuss it with them. He slept in a separate bed, by himself, downstairs, wholly removed from the bedrooms of other family members. This was necessitated in part by the breathing difficulties that he encountered when climbing stairs after his diaphragmatic tear repair. He told me however, that he would have slept downstairs on the sofa anyway. He said that

he refused to consider sleeping with his wife as long as he had a colostomy.

Mr C. had not returned to work; the only social contacts he made were with people he met while he was taking walks. He and his wife had no visitors and visited no one during the time he was at home waiting for closure surgery.

Mr. C.'s feelings about his colostomy had upset his entire lifestyle. Because he knew it was temporary, he felt that he did not have to try to make any permanent adjustments. He tried to ignore his colostomy completely. By not sharing the situation with his family, he could pretend that it didn't exist. Had the colostomy been permanent, I feel that Mr. C's period of adjustment would have been a long and rocky one.

Healthy emotional recovery

An article by Dericks and Donovan[4] identifies four developmental stages that the ostomy patient must work through before optimum rehabilitation can be reached. These stages are narration, visualization and verbalization, participation, and exploration.

Mrs. S. eventually worked through all these stages and was well on the road to healthy emotional recovery. Mr. C. was still unable to refer to the stoma by its correct name, one indication that he had not yet learned to integrate the stoma into his body image. Both were able to participate in their own care, Mrs. S.more enthusiastically.

By the time Mrs. S. left the hospital, she had already begun to master the exploration stage, through her visiting rounds on the hospital ward, and by having an extended number of visitors while she was in hospital. Mr. C. on the other hand was fearful and hesitant about resuming normal social functions; in fact, he refused to do so. His refusal to visit anyone or return to work while his colostomy was still in place indicated his inability to reintegrate his body image; and his self-concept suffered.

The awareness of a body image is one that begins to develop in infancy and grows throughout the lifetime of every individual. Our feelings about our own bodies affect our lives.

As nurses, we are often faced with the individual whose body image has been disturbed. In order to help, we must know first of all how this person feels about himself and how he has seen himself in the past. Dealing with anyone who undergoes a traumatic shock to his body image requires nursing care aimed not only at the physical cause of the disturbance but also at the emotional center of the problem.

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Almost every nurse who has worked with ostomy patients has met the patient whose temporary colostomy became permanent, or the patient who became a recluse during the time he had a temporary colostomy. She may also have encountered the individual who refused to care for the colostomy at all — because it was only temporary, or who developed serious changes in behavior that continued even after colostomy closure. All of these situations should prompt us to pause and take a closer look at the person with a temporary colostomy. In the world of ostomy patient care, this person may have become the lost soul with limited access to the resources available to those with permanent colostomies.

People with temporary colostomies

Are we meeting their needs?

Robin Young Wood
Pamela Gaherin Watson

As we look at the way in which we meet the needs of the individual with a temporary colostomy, we should ask ourselves an important question — "Is the approach we use with the temporary colostomate subtlely contradictory to the philosophy of rehabilitiation that we offer to those with permanent colostomies?"

The approach of the nurse, the surgeon and other caretakers towards those with temporary colostomies most often focuses on the transient nature of the colostomy experience, with an optimistic emphasis on a return to normal life following colostomy closure. What does this approach convey to the person with a temporary colostomy?

It may convey strongly negative feelings about the stoma, suggesting to the patient that the colostomy is only acceptable because it represents a time-limited experience. This attitude may in fact create problems for patients with temporary colostomies. For example, it may increase the patient's anxiety about stoma closure. If the situation arises that the colostomy cannot be closed, it may leave the patient with the feeling that he cannot cope. Either situation may result in the patient's depression, isolation, and withdrawal.

Looking more closely, it is easy to see that the rehabilitation needs of the patient with a temporary colostomy are as complex as those of the person with a permanent colostomy. In both cases, the procedure is life-saving. We still need to recognize the assault on the individual's intact body image brought on by the presence of the stoma. Our emphasis ought to be on helping the person and his family to live full lives.

It is not uncommon to hear a patient state that he plans to remain at home — away from people — as long as the stoma is present. This isolation may include withdrawal from family relationships and sexual activities. Such interruptions of normal patterns of living are obviously not in the best interests of the individual. Irreparable changes may occur unnecessarily in the patient's life, in relationships that are meaningful and important to him.

John H. provides us with an example of how normal life can be interrupted unless a positive adaptive response is made to a temporary colostomy. John was a twenty-two-year old man who was hospitalized for intestinal obstruction following colostomy closure. He refused to talk about his experience with the colostomy. He stated that he wanted to forget that he'd ever had it. He also indicated that he had become alienated from his family and friends while he had the temporary colostomy, and that he was now having great difficulty reestablishing these relationships.

Situations like this can be avoided by our careful attention to the rehabilitation plans we develop and to the unspoken messages that we convey. The plans we develop ought to include attention to the patient's stoma management and activities of daily living.

Stoma management

Learning the skills necessary to manage the stoma is an important component of the rehabilitation process. The irregular configuration of the loop colostomy stoma and the presence of the mucous fistula, or distal non-functioning colon in a double-barrelled colostomy, make stoma management somewhat different from the management of a permanent colostomy.

A special gasket appliance with a plastic

Types of Temporary Colostomies

The types of temporary colostomies usually created fall into three major categories as shown in Figure 1. Loop colostomies and double-barrelled colostomies are most common. The loop colostomy is often performed in emergency situations as it is a relatively simple surgical procedure.

The distal, non-functioning end of the double-barrelled colostomy is often referred to as a mucous fistula. This term is applicable whether the stoma is adjacent to the proximal stoma or placed elsewhere on the abdomen. A temporary colostomy can be performed in the right, transverse or left colon.

The Hartmann pouch is used infrequently as the resting segment buried in the intrabdominal cavity often adheres to other pelvic organs, and at closure it is difficult to extract and mobilize.

Pathophysiology

Most temporary colostomies are created to divert the fecal stream because of diverticular disease, carcinoma of the colon or trauma.

Diverticular Disease

Diverticular disease can lead to obstruction or perforation requiring surgical intervention. Surgery is often performed in three stages:

- A loop colostomy is instituted as an emergency procedure to relieve obstruction above the affected colon segment.
- When the patient's acute condition has subsided, usually within seven to ten days, the diseased portion of colon is surgically removed.
- The temporary colostomy is closed after allowing about three months for the distal colon to rest and heal.

Carcinoma of the Colon

Carcinoma of the colon may not be detected or diagnosed until the patient demonstrates symptoms of intestinal obstruction. Often, when the disease has progressed this far, the cancer is not resectable. A temporary colostomy will be performed proximal to the tumor and radiation may be initiated to shrink the tumor mass. Although the tumor may respond initially to radiation, the disease process is often advanced and a deteriorating course of illness can be expected. Local recurrence and metastasis is likely. Chronic disease leading to deteriorating health may preclude colostomy closure at a later stage. In these situations, the colostomy is *palliative* — not temporary.

Trauma

Trauma from gunshot or stab wounds to the abdomen or perineum usually necessitates emergency surgery. The colon may also be traumatized without penetration through automobile accidents, falls, or assault with blunt instruments. Most temporary colostomies caused by trauma can be closed in three to four months, but complications may prolong the time until closure, or, make closure impossible.

Temporary colostomies may be performed for many other types of bowel pathology, but the incidence of these is relatively rare. They include rectovaginal fistula, ischemic colitis, sigmoid volvulus, endometriosis of the colon, congenital anomalies (e.g. Hirschprung's disease), post-irradiation stenosis.

Factors Influencing Closure

The time lapse between colostomy construction and closure varies widely with individuals. Considerations are given to cause of colostomy, the age of the patient, his general state of health, and complications. The lapse may be from zero to fifty weeks, but generally closure is performed within eight to twelve weeks.[1] A substantial number of patients who think their colostomies are temporary find that closure is not possible. This fact constitutes a real though often unspoken fear for all persons who have temporary colostomies — the fear of having to live with the colostomy forever.

Complications of Surgery

Complications of surgery which interfere with patient well-being may develop prior to closure. Wound infection, peristomal or intrabdominal abscesses, fistula formation, and peritonitis are common. In addition, these patients are not exempt from the general post-operative complications of atelectasis, hypostatic pneumonia, thrombus and embolus formation and hypovolemic or endotoxic shock.

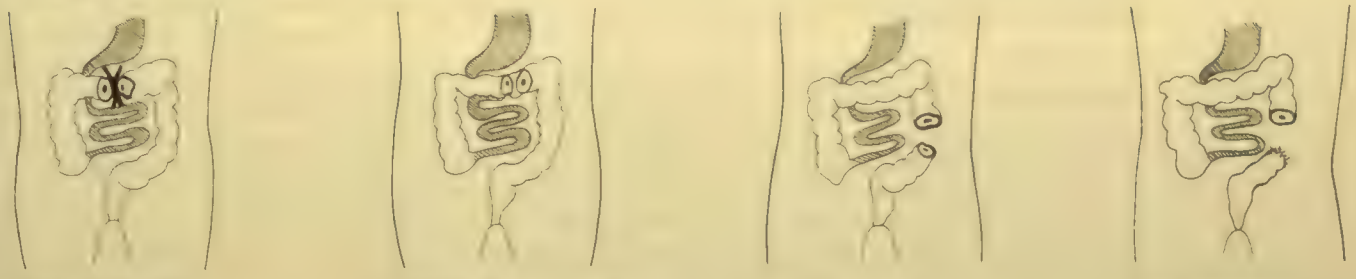
Even after closure, the person is not always healed. Complications occur in as many as 25-44% of patients post closure. Colocutaneous fistula, incisional hernia and wound sepsis are the most common post-closure complications.[1,2,3,4] Other post-closure complications include wound sinuses, obstruction at anastomosis site, peritonitis, and death. These complications are rare. However, the view that colostomy closure is a minor surgical procedure without substantial risk to the patient is fallacious. Patients' fears regarding the operation are well-founded and should be recognized.

The Age Factor

Age is an important consideration for the physical and psychosocial rehabilitation of persons with temporary colostomies. While a colostomy may be necessary at any age, the person undergoing this surgery is most often over sixty. Acute diverticular disease and cancer of the colon are largely diseases of a geriatric population. These people may already be at a greater risk for debilitating disease prior to the assault on their gastrointestinal systems. Further, they are certainly more prone to developing complications after both the initial surgery and the surgery for closure. Trauma is more common in young adults but is not reserved for any age-specific population and may be superimposed on the aged and infirm as well as on younger, more resilient persons.

Figure 1

Types of Temporary Colostomies



Loop Colostomy
A loop of colon proximal to the diseased portion is brought out to the abdomen and supported there with a plastic bridge or rod. The exposed colon is then cauterized to create an opening. The bridge or loop is usually removed after several days.

Double-barrelled colostomy
The colon is surgically divided. The proximal or functioning segment and distal or resting segment mature as two separate and adjacent stomas on the abdomen.

End Colostomy with Mucous Fistula
This is the same as a double-barrelled colostomy except the distal (resting) stoma is matured away from the proximal (functioning) stoma. The distal stoma is termed the mucous fistula.

End Colostomy and Hartmann Pouch
The colon is divided in surgery and the proximal (functioning) stoma is matured on the abdomen. The distal (resting) colon is sutured closed and returned to the intrabdominal space. No distal stoma is present on the abdomen.

bridge and karaya seal is available for use the loop colostomy. The plastic bridge or glass rod is removed before the patient is discharged from the hospital. The Loop Ostomy Gasket with Karaya Seal* may continue to be used after discharge, or an open-ended disposable appliance with an adhesive backing large enough to accommodate the stoma may be selected.

Most double-barrelled colostomies are constructed so that the distal non-functioning end of the colon is not directly adjacent to the proximal stoma. In this case, an open-ended disposable appliance with adhesive backing is used over the proximal stoma. The mucous fistula (distal non-functioning colon) is covered with a four-by-four gauze pad. The patient can expect mucus to drain from this fistula in gradually decreasing amounts.

The patient should know that in time, both the loop colostomy and the double-barrelled colostomy stomas become less edematous and therefore easier to manage. A skin barrier such as a karaya ring or stomahesive should be used with both types of colostomies to prevent skin breakdown.

The patient can achieve odor control by using an odor proof appliance or a commercial liquid deodorant that is placed in the appliance. Patients with temporary colostomies can be encouraged to maintain their usual diets, omitting only those foods that may cause diarrhea or excessive production of flatus.

Activities of daily living

The patient with the temporary colostomy should be encouraged to resume his own normal patterns of living as soon as he is physically able to do so. The stoma care routine can be planned to fit comfortably into the person's pre-illness hygiene schedule and should not interfere with his usual daily habits.

The nurse ought to emphasize preventive health measures. The patient can be advised of those signs and symptoms that warrant the attention of their doctor, signs such as constipation, excessive watery stoma output or cessation of stoma output. Knowledge about his own care helps the patient to take responsibility for himself.

The patient with a temporary colostomy needs the psychological support necessary to help him maintain his relationships with others. The need for sexual counseling should not be overlooked. Frequently the patient's fears of appliance leakage, odor, or damage to the stoma make him reluctant to engage in sexual activity. His altered body image and loss of self-esteem may also interfere, as well as real or imagined distaste on the part of his partner. Open discussion and exploration of anticipated problems involving the nurse, patient and his partner may be helpful.

Any nurse working with ostomy patients can play an extremely important role in determining the approach of other members of the health team towards the temporary colostomate. Conferences with surgeons and staff nurses help to assure that all will maintain a positive attitude towards the patient and his stoma experience. Those involved should all be aware of the importance of avoiding an emphasis on the transient nature of the stoma, focusing instead on living with the stoma as long as it exists. All members of the health team need to be aware of the effects of their attitudes on patient welfare.

The individual who undergoes surgery for the creation of a temporary colostomy has many of the same rehabilitation needs as the permanent colostomate. Rehabilitation goals should be identified and measures instituted to help the patient meet these needs early in his hospitalization.

Health care providers may be tempted to view this individual's needs as less critical than those of a person whose colostomy or ileostomy is permanent. But the sudden loss of control and change in body image accompanying colostomies are catastrophic events for either individual. A sensitive nurse will respond to the needs of a temporary colostomate with the same degree of supportive understanding and with the same careful teaching that she would use in caring for the patient with a permanent colostomy.

*The Loop Ostomy Gasket with Karaya Seal is a Registered Trademark of Hollister Inc., Chicago, Illinois.

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ALTERNATIVE BIRTH CENTERS



Alison Rice
Elaine Carty

"A hospital is a splendid place, but it is not, in my view, a place in which the most beautiful celebration in the history of a family, the welcoming of a new member into it, should occur."[1] These are the words of anthropologist Ashley Montagu. More and more, this sentiment is being expressed by childbearing couples who wish to bring "birth back to the family." However, in Canada there are few alternatives to the conventional hospital birth. In the article that follows, the authors describe four U.S. Alternative Birth Centers (ABCs) that attempt to give the birth experience back to families while maintaining excellence in obstetrical care.



In this age of consumer protection and self-help groups, it is not surprising to find childbearing women and their partners expressing dissatisfaction with traditional maternity care services. Many lay persons have become increasingly knowledgeable about the processes of pregnancy and birth and wish to share in the responsibility for their own care during this time. Often, this leads to conflict with the prevailing attitudes of health professionals. When this happens, the couple feels frustrated in their attempts to seek a childbearing experience which is not only physiologically healthy but also psychologically satisfying.

Signs of dissatisfaction

How do we know that couples are dissatisfied? Childbirth educators are now teaching couples who are eager for information about the pros and cons related to many of the traditional childbirth practices: women ask physicians about their philosophy on such measures as the use of medications during pregnancy and birth, the necessity of episiotomy and separation of parents and infant at birth. As well, hospital personnel find their established routines are being questioned with increasing frequency; sometimes, these routines are rejected outright. Here in Vancouver, the Maternal Committee of S.P.A.R.C. of B.C.[2] has received many letters from women and men sharing their feelings about their personal childbirth experiences. Some letters express joy, others express sadness and still others anger.

Disenchantment with hospital obstetrical care is almost certainly one of the reasons behind the increasing number of home births. In general, the medical profession has not supported this alternative and, in fact, discourages its members from attending at home births.

Nonetheless, the home birth movement grows as couples, many of whom are professionals, value what they see as the physical and psychological benefits of giving birth at home. It is difficult to accurately assess the number of births that are taking place outside of the hospital but it is estimated that in Vancouver there were approximately 300 such births last year. A recent article on home birth indicated that only 2% of births in Canada take place out of hospital but that there has been an increase of 62.5% in the number of home births in the Toronto area in the past year.[3] Clearly the numbers are growing; yet the present health care system is extremely slow in responding to the needs and desires of these families.

But what is it about the present system in Canada that is causing dissatisfaction? Many women and couples have assumed the responsibility for informing themselves about pregnancy and birth; they want to be involved in decision-making about their care. But many are not allowed to be. They seek to actively participate in the process of developing their family in a healthy way. Simply following instructions based on the information health professionals choose to give them is no longer enough. Some couples feel that the uninviting environment of the hospital, embraced in rules and regulations, interferes with the total experience of childbirth in terms of personal satisfaction and family development. Vaughan has commented, "It may really be a disaster that the medical model — or, still worse, the surgical model — has been adopted for the birth of a baby, which is actually a social event. I think it is about time that we re-created the birth of an infant as a social event, taking it out of the medical arena and giving it back to families."[4] What are the alternatives?

Experiences in the U.S.

In the United States a number of innovative programs have begun to appear in recent years. These projects, commonly called Alternative Birth Centers (ABCs), attempt to give the birth experience back to families while maintaining excellence in obstetrical care. Philosophically the approach of these centers is similar to family-centered hospital maternity units, however, the implementation differs for important reasons. Couples are expected to actively participate in decisions about their care so that their individual wishes and needs can be met. Many couples see birth as a spiritual and social experience, one which is enriched by being shared with loving family and friends. Bonding occurs, with all those who are present at the birth,[5] not only between the parents and newborn infant. The sharing of this experience is encouraged in ABCs in the belief that it provides a wider support system than is usually available to the nuclear family. Nurturing behaviors are enhanced and family relationships strengthened.

Parents, family and friends are considered part of the birth team and are supported by skilled professionals including nurse-midwives, nurses and physicians. Professionals are trained and equipped to recognize and handle deviations from the normal but the focus is on non-intrusive, natural and supportive care to enhance the highly emotional childbirth experience for the family.

Typically, the physical settings provide pleasant, home-like surroundings for labor and birth in an attempt to facilitate relaxation and reduce the anxiety inherent in a hospital environment. The programs offered at the centers include antepartum, intrapartum and postpartum care for low-risk women plus a variety of educational programs pertinent to childbearing and parenting.

In an attempt to learn more about these centers, we visited both in-hospital and out-of-hospital Alternative Birth Centers. It seems clear to us that health care professionals are making these centers a viable and valued part of their communities.

ABC No. 1

The Alternative Birth Center at the San Francisco General Hospital is an example of an in-hospital setting which provides a different kind of birth experience than the traditional obstetrical unit. The birth rooms, located within the obstetrics department, are modified hospital rooms. Furnishings such as a couch, comfortable chairs, a double bed for the woman to labor and give birth in, cheerful decorations, plants and other amenities create a homelike environment. At present, 25 to 30 women deliver in this setting each month.

Women who register at San Francisco General Hospital for prenatal care, and who are assessed to be low-risk, are offered the option of being cared for by a certified nurse-midwife or a physician. Low-risk patients (defined by clearly stated criteria), particularly those registered with the midwifery service, may elect to utilize the Alternative Birth Center rooms for their labor and birth.

Women using the ABCs must have a support person with them in addition to the medical attendant. Usually, the rooms are used by midwifery service patients, however, some resident obstetricians and family health physicians also use them. In this case a qualified "labor coach" approved by the ABC staff must be in attendance.

Since the emphasis is on natural, prepared childbirth and on responsible participation by the couple (or woman and her "labor coach"), one of the requirements is attendance at a childbirth education course either at San Francisco General or in the community. In addition, the Alternative Birth Center staff give a series of three classes specifically designed for people who plan to use the alternative birth rooms.

Measures aimed at ensuring safe, high quality care are built into the program. Problems and circumstances necessitating transfer from the birth rooms are clearly defined. These possibilities are discussed with prospective participants in the class sessions. Other safeguards include the proximity of emergency facilities and back-up medical staff.

The professional approach to the labor and birth is a calm, encouraging, non-intervening one. Support persons are allowed to attend as desired by the mother and provisions may be made for the presence of her children. As many decisions as possible are made by the woman subject to the judgment of the attendant. Careful consideration is given to enhancing

parent-infant bonding, for example delaying silver nitrate eye drops for 30 minutes to one hour after birth, so eye contact between parent and infant can be established early.

Early discharge of the mother and infant, between six and 48 hours postpartum, is possible provided there is live-in assistance in the home for at least three days, access to telephone and transportation and the condition of both the mother and baby is satisfactory. Patients who do not wish to go home early or require additional in-hospital care are transferred to the regular postpartum ward. ABC staff visit early discharge patients in their homes within 24 hours for those discharged six hours postpartum and within 48 hours for those discharged 12 hours postpartum. In addition, telephone contact is made in the interval between discharge and the home visit.

ABC No. 2

The Alternative Birth Center at Mt. Zion Hospital and Medical Center in San Francisco is similar to the one at the San Francisco General Hospital. Hospital rooms have been converted to birthing rooms and decorated to provide a homelike comforting atmosphere. Wall-to-wall carpeting, a double bed, soft lamps, plants and bean bag chairs are all features of the Mt. Zion Alternative Birth Center. The parents have access to a large record collection, many of the records contributed by couples who have used the room. Couples are also encouraged to bring personal comfort items from home.

The Center is available for use by patients of house staff or private physicians. At present, there are no midwives attending deliveries at Mt. Zion. As at San Francisco General, specific criteria relating to the woman's health, course of the pregnancy and preparation are clearly spelled out. The ABC at Mt. Zion Hospital is staffed separately from the Obstetrics unit. Although patients are expected to have a coach/support person, the Center guarantees one-to-one nursing care. The woman may have whomever she chooses at the labor and birth. Children attending are screened for infectious diseases and must have adequate adult supervision. The prime concern is the woman's desire and tolerance for company as labor progresses.

The mother and infant recover in the birth room for four hours and then are transferred to the postpartum ward. Discharge home can occur as early as six hours, again depending on mother's and baby's condition. Home visits are made by the ABC nurses on the first and third postpartum days. The purpose of these visits is two-fold: assessment of the mother and infant, and teaching.

The basic cost of the hospital services at Mt. Zion's ABC is $400. This includes two orientation classes, an optional antepartum home visit, the special nurse during the stay in the birth room, stay up to 48 hours in hospital plus the home visits. It does not include the physician's fee. In the U.S. there is considerable competition for maternity patients, particularly among private hospitals. This service at Mt. Zion attracts patients and according to the nurses at the Center, it is a profit-making service for the hospital. Although patients are pleased with the lower cost of this service (a difference of about $400. - $500. to the standard hospital cost) their main reason for coming to the ABC is the style of birthing, and the total experience.

ABC No. 3

New York's Maternity Center Association operates an out-of-hospital Childbearing Center in a townhouse on East 92nd Street in New York City. An obstetrician/nurse-midwife team provides care to expectant parents who can anticipate a normal, uncomplicated childbirth and for this reason a very careful medical screening process is applied throughout the pregnancy, labor and birth.

The midwives offer preparation for childbirth and parenthood classes and all those couples who plan to give birth at the center are encouraged to participate. The women become involved in their own care in many ways. For example, they weigh themselves, test their urine and record the findings on their chart. They read their chart and discuss all aspects of their care with the nurse-midwife or doctor and make plans with the midwife for the way they would like the birth to be.

Every attempt has been made to create a relaxing environment at the Childbearing Center. A living room, kitchen, outside garden and two bedrooms are available to the laboring woman and her support person. Children are also welcomed at the Center.

A nurse-midwife and midwife assistant attend the births and an obstetrician is always on call. A non-intervention philosophy characterizes the practice of the nurse-midwives. Parents inspect, touch and cuddle their babies immediately after birth, never being separated unless some complication arises where mother and/or infant have to be transferred to hospital. There are three hospitals within a ten-minute drive of the Center. After the birth, the baby is examined by a pediatrician who discusses the examination with the parents. Families leave the Center when the condition of both mother and baby stabilizes, usually within 12 hours after the birth. The Center's fee also includes two home visits by the Visiting Nurses Association of New York City. The woman and baby are examined at the Center within a week to 10 days following the birth and again at five to six weeks postpartum. Parents report that they are delighted with their experience at the Childbearing Center. The cost of the total program is $750, another attractive feature of the Center since a normal childbirth occurring in a hospital in New York City costs about $1,500.

As a result of the occurrence of factors associated with increased risk to mother and baby, approximately one-third of the women have been transferred out of the Childbearing Center program at some time during the antepartum, intrapartum or postpartum period. The transfers have involved mostly primiparous women and none of these have involved an emergency transfer.

At present, the staff at the Center feel the critieria used in assessing high risk cases may be too strict. As they gain more experience in an out-of-hospital setting, the staff hopes to be better able to identify those factors which truly



indicate the need for a hospital birth. A research study comparing data on mothers and infants giving birth at the Center with a matched group of mothers giving birth at a hospital is currently underway.

4 ABC No.

Lucinia, a Birth Center in Cottage Grove, Oregon, consists of a house and adjacent offices decorated in Scandinavian fashion. The program offered by this out-of-hospital birth center is similar to that of the center in New York City. Expectant women are carefully screened for any high risk factors as only those parents expecting a normal pregnancy and birth are accepted into the program. The Lucinia Birth Center registers about 20 new clients per month and is in such demand that many more must be turned away. A nurse-midwife and obstetrician provide care to the families while experienced nurses are involved in the educational program. The Birth Center offers an extensive range of educational programs including classes for childbirth preparation, parenting, grandparenting, nutrition, fitness, parent effectiveness training, babysitting and mother's helpers.

"The philosophy of the Birth Center is as a triangle, placing the pregnant couples at the apex or top in a leadership role with rights and responsibilities for their own health care. Across the base of that triangle are the professionals with different areas of interest and expertise. Though those areas often interface they are also separate professions working in harmony."[6] From February 1, 1976 to February 1, 1977, 275 families were involved with the Birth Center. The outcomes of the pregnancies of all women enrolled at the Lucinia Center (now 150) are shown in Table 1.[7]

Table 1

Outcome	Number	Percentage
Spontaneous abortion	13	8.6
Advised to transfer to other facility due to past obstetrical history or distance	3	1.9
Moved out of area	15	9.87
Lost to follow-up	5	3.31
Transferred to Home Delivery with traditional birth attendant or Certified Nurse-Midwife in area	10	6.6
Delivered at Birth Home*	78	51.3
Delivered at Community Hospital or Medical Center	26	17.2
Not pregnant	2	1.3
Total	152	100

*All normal spontaneous vaginal deliveries of viable infants with Apgar greater than 7 at 1 minute.

How parents feel

Parent satisfaction with all of the Alternative Birth Centers we visited is reported to be high. To date the statistical data available on perinatal, infant and maternal morbidity and mortality suggest that such centers can provide a safe alternative to traditional obstetrical services for selected clients. As further studies are carried out to evaluate these programs, we may gain some valuable insight into the effect of environment and a non-intervention philosophy on the process of labor and birth as well as on the family's ability to nurture.

Alternative Birth Centers represent positive consumer initiated change in the American health care delivery system. The psychological benefits and lower cost offer an attractive alternative to families.

What's happening in Canada?

In Canada, we too are faced with consumers who are actively seeking a more satisfying childbirth experience. Moreover, both the government and the taxpayer are concerned about the rising health care costs in this country. Financial ceilings imposed by many provincial governments on the health care dollar are making us take a look at less costly alternatives to traditional hospitalization that still maintain a high quality of care.

Some encouraging trends are already in evidence in our maternity units. To a great extent, these trends have been influenced by consumer demands for greater participation in the birth process and by research which shows that such activities enhance maternal-infant-family bonding. Many hospitals, for example, are liberalizing sibling visiting and encouraging participation of fathers throughout the hospital stay.

Some are attempting to provide a setting which appears less institutional. McMaster University Medical Centre in Hamilton, Ontario is an example. Here the woman can labor and give birth in a brightly decorated room. Her partner is always welcome and she is not separated from her baby after birth.

Even with these changes, however, much remains to be done. The rationale for traditional hospital procedures needs examination and clearly we need to further examine the effect of the hospital environment on the birth process. Also we need to re-examine our roles as health care providers and the way in which these roles relate to the expressed wishes of childbearing families for more control over their care.

Surely the time is ripe for those involved in the character of the health care system to respond to consumer demands and social needs by designing innovative health services.

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Along with a group of nursing colleagues at the University of British Columbia, they are engaged in planning an alternative to conventional hospital delivery. Work is in progress to formulate a proposal for a demonstration project using nurse-midwives, nurse specialists, obstetricians and pediatricians to provide comprehensive care to low risk women and their families in a small out-of-hospital birth center. The formulation phase of this project is funded by Health and Welfare Canada.

HOSPITALIZATION

IS IT ALWAYS A NEGATIVE EXPERIENCE?

In recent years much has been written about patients' negative reactions to hospitalization. In nursing journals as well as in lay publications, first person chronicles of sad and tragic hospitalization experiences are fairly common.[1,2] But are all hospitalization experiences negative?

Recent nursing research suggests that they are not. In the article that follows, the author presents data, raises questions and you, the nurse, are asked to draw your own conclusions.

Gail Patricia Laing

The experience of hospitalization is thought to harbor many potentialities for degradation, depersonalization and threat to self-esteem for patients. Brown and Field, among others, have pointed out that the authoritarianism and bureaucratic social structure of the hospital with its rigid schedules and unvarying routines, and the loneliness, isolation, loss of privacy and identity of the patient tend toward loss of control and loss of self-esteem.[3,4] Brown's image of "the anonymity of the patient in a horizontal position between white sheets," or "a situation in which going to the bathroom is regarded as a privilege" is particularly poignant.[5]

With this in mind, I wondered whether or not all patients experienced negative feelings while hospitalized. I decided to include questions directed towards the patients' reactions to hospitalization in a study that I was conducting on the self-esteem of patients who have suffered a myocardial infarction[6] (See Table 1). The sample was comprised of twenty-nine English-speaking Toronto residents who had been admitted to one of four city hospitals with a diagnosis of myocardial infarction. Twenty-five of the subjects were male, four were female. All subjects were between the ages of 40 and 81 years with nine of the patients having a previous history of myocardial infarction. In all of the hospitals, patients were admitted through the emergency department to a coronary care unit and then transferred to a general medical ward for the hospital convalescent phase of their illness. Staff in all hospitals included registered nurses and registered nursing assistants. One hospital had a clinical nurse specialist for teaching and continuity of care with coronary patients; another hospital had delegated these duties to the assistant head nurse in the coronary care unit. The other two hospitals had no organized teaching program or liaison from the coronary care unit to the general ward.

The interview

I interviewed the patients in their homes during the second week after their discharge from hospital. The interviews were scheduled after the patients' discharge to minimize bias arising from fear of reprisal if they said anything derogatory about the hospital while still dependent upon its care. When conducting the interviews, I identified myself to the patients as a nurse but emphasized that I was not connected with any particular hospital. The interview was tape-recorded and was semi-structured; that is, most of the questions could be answered with a "yes" or "no", but I encouraged the subjects to elaborate on the "yes" and "no" answers. Open-ended questions also permitted the subjects to express additional concerns. (See Table 1)

Table 1

Questions in the study re hospitalization.

1. Did you feel that you were treated with respect?
2. Did you feel valued as an individual?
3. Did you feel that you had control over what was happening to you in the hospital?
   a) did you want to have control?
4. How would you describe the atmosphere in the hospital? (friendly? impersonal?)
5. Did you feel isolated?
6. Did you feel that the hospital personnel were concerned about you?
7. Did you feel cut off from family and friends?
8. Did you feel that you got enough emotional support?
   a) from family?
   b) from nurses?
   c) from doctors?
9. Were you kept informed about your progress?
10. Did you have enough opportunity to ask questions?
11. Were your questions answered to your satisfaction?
12. Were procedures and tests well explained?
13. Did you understand the hospital routines?
14. Did you make any of the decisions about your care?
15. Did you want to make the decisions?

Do you have other reactions to your hospitalization that we have not mentioned? If so, would you tell me about them?

Findings

Subjects' responses to questions regarding their hospitalization were generally positive. Analysis of individual subject's responses across all the questions showed an average of only three negative responses out of a possible eighteen per subject. The range of negative responses was from zero to ten per subject. In Table 2, the questions were grouped for clarity into categories of (a) general ambience of the hospital, (b) feeling of isolation, (c) dependence-independence, (d) emotional support, and (e) information.

Most of the 29 subjects were satisfied with the general ambience in the hospital. They stated that they were treated with respect and felt valued as individuals. They reported that hospital personnel were concerned about them and described the atmosphere as friendly. Seven subjects singled out the staff of the coronary care unit as being particularly friendly and concerned, and some subjects expressed surprise at the excellent, speedy treatment they received in the emergency department. Negative responses were usually directed at perceived ill treatment by one or two particular staff members.

Only three subjects indicated they felt isolated in the hospital, indeed many subjects expressed feelings of enhanced closeness and support from their families during this period.

In answer to the questions: "Did you make any of the decisions about your care?" and "Did you want to make the decisions?" fourteen subjects reported that they had no control over what was happening to them in the hospital and eighteen subjects reported that they made no decisions. However, only three of those stating that they made no decisions indicated that they would like to have made more decisions about their care. The other 26 subjects stated they felt either control or decision-making on their part was inappropriate or they were satisfied with the level of control that they exercised, even if it was minimal.

Sixty-five out of a total of eighty-seven responses to questions regarding emotional support were positive. The proportion of positive to negative answers was the same regarding support from family, nurses and doctors. Interpretations of emotional support varied as the following responses indicate: "they used to kid me along," "they were kind and thoughtful," "they were cheerful," "their attitude was assuring." Two subjects who answered negatively indicated that doctors and nurses were too busy to give any emotional support. Three subjects said they did not need any emotional support.

Subjects were generally satisfied with information they received regarding hospital routines, procedures and tests. However, nine subjects expressed dissatisfaction with information given them about their progress. They gave reasons such as "the doctor is too busy", and "they deliberately don't tell you." There was a strong impression that patients look exclusively to their doctor and not to nurses for information and answers to questions regarding their progress.

Older subjects viewed their hospitalization more positively than younger subjects; subjects who were suffering their first heart attack took a more negative view of their hospitalization than those who had had a heart attack before.

Negative or positive?

In general, the responses to questions regarding the subjects' reactions to hospitalization do not support the contention in the literature that hospitalization is a degrading, depersonalizing experience. Although these results could be spurious due to small sample size and other limitations in the study, there are other possible explanations which are worth exploring.

Perhaps statements in the literature by Brown[7], Wu[8], Field[9] and others are not applicable to the findings in this study because:

- their studies refer to long-term hospitalization rather than to short three-to-four week stays such as these subjects had;
- the literature refers to the situation in hospitals in the United States but not Canadian ones;
- the literature refers to the hospital situation in the 1950's and 1960's but not the 1970's.

Perhaps with the current focus on research and the present interest in coronary care some of the past problems in hospitalization have been overcome. Finally, perhaps there is something unique about the hospitalization experience associated with myocardial infarction.

Another consideration is that satisfaction is a function of how well expectations are met; that is, if expectations are low, satisfaction is easily achieved. In this regard, it is interesting that the older subjects tended to view their hospitalization more positively than younger subjects. The age differential might be an indication that the hospitalization experience is improving. Older subjects, whose

expectations might be lower because of past experiences, might tend to view their hospitalization more positively than younger subjects with higher expectations of the hospital. On the other hand, studies of the normal aging process in our society indicate that men past sixty seem to move to a more passive, dependent, compliant position whereas the helpless dependent role is more alien to younger people, particularly men.[10] Thus the older person might more readily accept the limitations imposed by illness and hospitalization and report a more positive experience.

Interestingly, questions specific to the subject of "dependence-independence" did not show an age differential related to the desire for control over the hospital experience. The age range of the four subjects who said they wanted to have control was from forty-eight to seventy-eight years.

Indeed the passive role appeared to be comfortable to the majority of subjects as evidenced not only by the responses to questions specific to control over the hospitalization experience but also by the large number of subjects who did not want to ask questions about what was happening to them. Perhaps the passive role, defined as an element of the sick role,[11] influences expectations which in turn explains the high rate of satisfaction with hospitalization. Illich[12] expressed a similar idea with his phrase "medicalization of expectations," whereby patients or clients, due to the extreme passivity of their role vis-à-vis physicians, accept the medical system's standards of care without question.

The other significant relationship between sample characteristics and reactions to hospitalization was that subjects who had had a previous heart attack viewed their hospitalization more positively than those who were in hospital with an M.I. for the first time. The subjects with a previous heart attack were perhaps more apt to have lower expectations engendered by more and longer experience with the sick role. Perhaps also they were more passive and content due to some familiarity with the experience than for subjects encountering the "unknown" for the first time.

The suggestion that possibly there is something unique about the hospitalization experience associated with myocardial infarction deserves further consideration. Certainly the intense, highly technical nature of the coronary care unit is a unique situation which might encourage subjects to feel that judgments and control of their care would be most properly delegated to those with superior knowledge and competence, a competence which they may feel they lack. The seriousness that people usually associate with a heart attack would add to their feeling of incompetence and thus influence their willingness to adopt a more passive role. The awe, loyalty and gratitude given to nurses and doctors who work in such a specialized unit and who guide patients through the extreme crisis of a myocardial infarction may help to explain the generally positive attitude of these subjects toward the hospital experience.

Table 2

Frequency and type of subjects' responses to categories describing reactions to hospitalization

Category of Question	Subjects' responses			
	Negative	Positive	Equivocal	Total
General ambience of the hospital	[illegible]	100	10	116
Feeling of isolation	3	53	[illegible]	[illegible]
Dependence-Independence				
Had control	14	15	[illegible]	29
Wanted control	4	25*	0	29
Made decisions	18	11	0	29
Wanted to make decisions	3	26*	0	29
Emotional support	6	65	16	87
Information	30	107	[illegible]	145
Total	85	402	36	522

*Marked positive if subject was satisfied with the level of control or decision-making that he had.

Negative response: The subject indicated feelings of dissatisfaction, unease or unhappiness.
Positive response: The subject indicated feelings of pleasure, satisfaction or happiness.
Equivocal response: A response which was not classifiable as negative or positive.

Summary

In conclusion, it appears that rather than anything definitive about the 'goodness' of the hospitalization experience in an objective sense, these findings are more plausibly interpreted as an indication of how well the subjects' expectations of hospitalization were met. Remember, too, that the data reflects a subjective rather than an objective analysis of the patient's experience. There is some indication that expectations of hospitalization were influenced by the patient's age and past history of myocardial infarction. Expectations may also have been influenced by the unique nature of the illness and by its treatment in contemporary hospitals. A possible bias due to the fact that the interviewer was a nurse cannot be ruled out.

In the final analysis these data raise more questions than they answer. Are there differences between the reactions to hospitalization of patients who have had a myocardial infarction and those of patients with other acute and chronic illnesses? Are there differences in the reactions of patients whose experience includes admission to a coronary care unit from those with the same diagnosis admitted to a general intensive care unit or a general ward? Studies done by clinical nurses who are alert to their patient's reactions to hospitalization may answer some of these important questions.

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This article by **Gail Patricia Laing** *(B.Sc.N., University of Saskatchewan, Saskatoon; M.Sc.N., University of Toronto) is based on a study entitled* Relationship of Self-Esteem and the Myocardial Infarction Experience. *It was written in conformity with the requirements for the degree of Master of Science in Nursing. Presently Laing is assistant professor of nursing at the University of Saskatchewan Saskatoon, where she teaches intensive care nursing.*



Photo by Health and Welfare Canada

Is there a knowledge/practice gap when it comes to caring for children in hospital? Last year the Association for Care of Children in Hospitals was able to compile a bibliography of more than 400 publications available to anyone who wanted to learn more about the hospitalized child, particularly his emotional and developmental needs.

In actual practice, however, many of the children admitted to Canadian hospitals this year will be the recipients of care that ignores much of what has been discovered about how to reduce the trauma of hospitalization and help them continue to grow and develop in the hospital setting.

Denise Alcock

In December 1976, the author set out to survey pediatric units throughout Ontario in an effort to learn more about how these hospitals are equipped to meet the non-clinical needs of the children who are admitted to them. Her findings are similar to the results of an earlier survey in the Maritime provinces[1] and indicate important ways in which hospitals in this country are failing to provide the facilities, personnel and environment that the pediatric patient needs.

The questionnaire

A total of 74 questionnaires were sent to all Ontario hospitals listed in the Canadian Hospital Directory as having more than 20 pediatric beds. Fifty-five hospitals (74%) responded; five of these respondents indicated that their pediatric units had been closed, leaving a survey base of 50 hospitals.

All questionnaires were addressed to the hospital administrator. In many instances, the administrator receiving the questionnaire designated a member of the nursing department to respond to the questionnaire. The rationale for the survey was explained as follows:

"It is known that illness and hospitalization interrupt a child's normal life activities and that this interruption can affect growth and development. It is also known that illness, treatment and hospitalization can be stressful and that stress can be harmful if a situation arouses more anxiety than a child can cope with. Therefore, pediatric care must include the opportunity for continued normal life activities, and ways must be planned to reduce anxiety and to help a child cope with his concerns.

This survey is an attempt to appreciate the different ways in which the hospitals in Ontario are dealing with concerns centered around the hospitalized child's emotional and developmental needs."

Findings

1. *Visiting hours*

Since one of the most fundamental means of diminishing anxiety in hospitalized children is to encourage the continued closeness of parent and child, the questionnaire concerned itself with visiting policies and whether or not parents could stay overnight.

- **Less than half (44%) of the hospitals responding to the questionnaire indicated that parents were permitted to stay overnight;**
- **34% said parents could stay but "only with special cases;"**
- **18% indicated that overnight stays are not permitted.**

Hospitals that have established open visiting policies and those which encourage care by parent units are helping parents continue to parent and are contributing to the child's sense of security in a strange environment. Parents who can visit at any time become more confident that twenty-four hour quality care is being maintained and their comfort with the hospital environment is felt by their child. Nursing staff do not experience the tension and congestion that restricted visiting hours impose on nursing units and they have more opportunity to share information and skills with parents concerning the care of their child. This can be particularly beneficial to parents who must care for their child during an extended convalescent period at home. Frequent and extended parent-child contact is essential to the parent-infant bonding process for the hospitalized neonate and young infant.

Four hospitals listed different rules according to the age of the child, as follows:

1. A hospital with open visiting for parents of children under fourteen, permits only six hours of visiting for parents with children *over* fourteen.
2. A hospital which permits eight and one-half hours of visiting for parents of children under twelve, permits eight hours for parents of children *over* twelve.
3. A hospital which permits nine hours of visiting for parents of children over thirteen, permits only eight hours for parents of children *under* thirteen.
4. A hospital which permits five and one-half hours of visiting for parents of children over five, permits only four and one-half hours for parents of children *under* five.

2. *Sibling visits*

Siblings of hospitalized children often worry alone and tend to experience less attention from their parents whose thoughts and presence are with the ill child. Younger siblings may even be separated from their parents and cared for by helpful friends or relatives. In some cases, schoolwork has been affected and regressive or neurotic behaviors noted in siblings of hospitalized children. Understandably, visiting by siblings needs to be monitored by nursing staff and in some instances may be undesirable, but the benefits to both the ill child and the sibling of continued contact while in hospital are obvious.

- **12% (6) of the fifty hospitals responding do not permit any visits by siblings;**
- **another 12% permit sibling visiting only on Saturdays and Sundays. This weekend visiting appears to exist primarily for the benefit of long-term patients and is usually limited to one or two hours on each day;**
- **36% of hospitals responding indicated that siblings were permitted to visit regardless of their age.**

Age restrictions on visiting exist in sixty-four percent of the hospitals surveyed.

Lower Age	Number of Hospitals
16	3
15	1
14	7
13	2
12	16
10	2
6	1
no restrictions	18

3. *Pre-admission orientation*

One of the accepted methods of reducing the emotional stress to which hospitalized children are subject, is familiarization with the hospital environment and procedures prior to admission.

- **40% of the hospitals that responded indicated that they make no provision for pre-admission visits of children to the hospital;**
- **16% indicate that if parents take the initiative to request an orientation to the unit before admission, their request will be met;**
- **28% have tours, slides or other pre-admission programs organized by nursing staff, auxiliary members or teen volunteers. The frequency of orientation program varies from weekly to monthly to "irregularly scheduled;"**

- **8% (4 hospitals) state that an orientation program is in the planning stages;**
- **10% have community slide-talk presentations especially suited to kindergarten and primary school children;**
- **4% mentioned that they distribute a hospital coloring book.**

4. *Provision for child-oriented care*
It is known that children express themselves through play, that they learn through play, socialize through play, and that they work out their problems through play. It is vital that children be given the opportunity to continue to play in hospital and nursing units which provide this opportunity to create a receptive child-oriented environment and a happier nursing unit.

If space that is allocated as playspace is at least a symbolic recognition of the need for the hospitalized child to play, then 96% of hospitals surveyed at least symbolically recognize this need. Only four percent said they have no playspace. The location or suitability of the playspace available was not determined by the questionnaire.

In response to a question asking "What concerns you most in terms of the emotional and developmental needs of the children in your care?", many respondents referred to the need for staff knowledgeable in child development and familiar with hospital procedures whose primary function would be to help the child cope with illness and hospitalization. Here are some of the concerns expressed:

"Presently nursing staff have time to look after physical needs of the child. An organized play program is needed to help make the child's stay in hospital less traumatic."

"Cuts in nursing staff leave permanent staff excessively busy with insuficient time to look after the child. Part-time staff have difficulty giving necessary support."

"Lack of consistency in staffing patterns to accommodate needs of children. Unable to assign patients to one person for any length of time so they can relate more easily."

"Need to find way to make staff aware of children's needs and how to cope with them and to find way to make staff comfortable with parents."

"There is a lack of understanding that pediatrics differs from other areas in the hospital."

"Not enough people trained and experienced in caring for emotional and developmental needs to properly cover these areas of patient care."

- **54% of the responding hospitals have paid staff who attend solely to children's emotional and developmental needs.**

Variance in the amount of coverage is wide. For the most part, staff concerned with children's activities work four hours per day and in others only three days per week. Only the larger institutions servicing children have evening and weekend programs.

The most commonly stated qualifications of staff responsible for children's activities in hospital are a degree or college diploma in education or recreation and experience working with children. The backgrounds listed however are diverse: nursing plus education degree; nursing plus early childhood education; teaching, recreation; early childhood education; behavioral science diploma; psychology degree; community college child care program; registered nursing assistant plus experience; twelve week on-the-job training.

These staff comprise separate departments in six hospitals. Three are large institutions caring for children and three are general hospitals with pediatric units of twenty-eight, thirty-one and forty beds respectively.

- **20% of responding hospitals set aside separate budgets to meet children's non-clinical needs.**

In one hospital a special gift fund is established and in three hospitals the auxiliary funds the program. In the remaining hospitals these programs are funded under the pediatric, occupational therapy or physiotherapy budget.

Staff dealing with children's activities report within the hospital structure as follows:

- administrator — 3%;
- assistant executive director — 11%;
- nursing department (director, coordinator or head nurse) — 55%;
- chief of pediatrics — 3%;
- chief of rehabilitation — 3%;
- physiotherapy department — 3%;
- playtherapist responsible to head nurse, (budget from occupational therapy) — 3%;
- not indicated — 19%.

5. *Schooling in hospital*
For children of school age, the focus of dai Monday to Friday activity centers around school. The continuation of schooling durin hospitalization or during an extended convalescent period at home enables the chil to maintain contact with a very important are of normal daily activity. It must not be assume that school means work and, therefore, will b stressful; many children enjoy learning and miss school. For some hospitalized childrer such as those who need to be on dialysis fo two or three days each week, schooling in hospital offers an opportunity to keep up academically with their peer group and keeping up with a peer group is difficult but very important to the chronically ill child's sense of self-esteem.

- **16% of surveyed hospitals have a teacher or teachers as part of the hospita staff but paid by a local board of education**

The most commonly identified persons t make the arrangements for schooling are: the doctor, parent, head nurse, public health nurse, child's school teacher or principal, chil life worker, play therapist or social worker. Some hospitals indicate there is difficulty in obtaining teachers for hospitalized children even if the child has already been out of schoc for the four-week period deemed necessary i order to qualify for hospital or home teaching

- **Twelve hospitals have space used b teachers as classroom space and these areas were noted as being play areas, sma conference rooms or classrooms. Where classroom space is not available or the child cannot be moved, teaching takes place at the bedside in the child's room.**

One hospital states that their Pediatric Committee sees the education of the child resting solely with the parents and not with the nursing personnel. This is a disturbing



The situation in other countries

In Canada, a number of persons feel that the Canadian Council on Hospital Accreditation should review the present requirements for accreditation of pediatric units and insist that the emotional and developmental needs of the children be considered in terms of policies and facilities before accreditation is granted.

What is happening in other countries?

In *Britain,* James and Joyce Robertson led the way in urging the formation of a parents' organization to work for changes in hospital care. Their efforts resulted in an official government statement, "The Platt Report," which among other things recommends that in all new hospitals, facilities for "living-in" be included in the planning of children's units.

In *Australia,* The Association for the Welfare of Children in Hospital prepared policy recommendations entitled *"Health Care Policy Relating to Children and Their Families"* which was declared the official policy of the Health Commission on September 1, 1975. This document states that parents should have the right of access to their children at any time, that play facilities must always be available, that parents should be encouraged to be involved in the care of their child, that care-by-parent units should be planned for all new hospitals, that it be mandatory for brochures to be available on the preparation of the child for hospital and that parents should be fully informed and have access to inquiry. There are many other special policy considerations included in this document.

In *Sweden,* on January 1, 1977, a new law was passed which reads as follows: "The principals of any hospital or other institution receiving children for care are under the obligation to make proper arrangements for offering these children participation in activities of the same kind as are provided by preschool or leisure time centers." To ensure that this law is carried out the National Board of Health and Welfare has become involved in the planning and the organization of play programs in all hospital children's units in Sweden.



statement in that it suggests a lack of appreciation of the benefits to the child, the nurse and the teacher of shared information and concerns regarding the child's schooling program.

6. *Volunteer programs*

Men, women and teens of both sexes who volunteer to work with children in hospital have more than time to offer. They bring with them their own areas of expertise and are one of the hospital's strongest links with the community. It is also the volunteer who realizes the lack of good children's literature or magazines for parents, or a specific playroom need, who prompts friends or clubs to meet these needs.

- **56% of the hospitals which responded have volunteers who work with children.**

The responsibilities of the volunteers would appear to vary greatly from hospital to hospital. Among the responsibilities noted are: to entertain, give TLC, feed, do crafts, transport patients, prevent fighting in the playroom, play with children, read to children, conduct weekly orientation program. One hospital has Early Childhood Education students two days a week in the playroom who work in a volunteer-student work placement capacity.

Implications

The number of responses (74%), personal notes from respondents expressing interest and requests for survey results, indicate a definite interest in questionnaire subject matter. For the most part, pediatric staff seem aware of children's needs but uncertain about the best way of dealing with these concerns.

Improvements do not always depend on the expenditure of large sums of money. Much can be done on pediatric units at little expense and, as Elizabeth Crocker discovered in The Maritimes,[2] these things *are* being done in settings where staff are aware of the potential impact of hospitalization on both children and parents. Policy changes are more a matter of attitude change than a matter of money, although, as Crocker notes, most hospitals need both guidance and money to meet child care objectives.

- **Nurses,** who fully appreciate the value to the child, the parents, the siblings and themselves of liberal visiting policies, can become advocates of more liberal visiting policies.
- **Nurses** who are fully aware of the significance of continued schooling for the long-term orthopedic patient or the chronically ill child will, when necessary, agitate for continued schooling for these children.
- **Nurses** who are fully convinced that pediatric care involves special programming to meet children's non-clinical needs will push for Child Life programs and volunteer assistance.

It is necessary for all of us to periodically examine our knowledge-practice gap to determine what more we ourselves can do and then mobilize our efforts in unison with disciplines with similar concerns in order to effect changes that will ensure better pediatric care.

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9 *To prepare a child,* Media Centre, Children's Hospital National Medical Center, Washington, D.C. 20009. 16mm, 32 min.

Denise Alcock, *R.N., B.Sc.N., S.R.N., M.A.(Ed), the author of "Hey, what about the kids?" has been chief of the Child Life Department of the Children's Hospital of Eastern Ontario for the past three years. The study on which her article is based was carried out in December 1976.*

A graduate of the University of Toronto School of Nursing she received her S.R.N. from Radcliffe Infirmary, Oxford, England, and her M.A. in education from the University of Ottawa. Before joining the staff of the CHEO, she spent three years as a Sister tutor at Radcliffe and four years with the Canadian Mothercraft Society doing prenatal and postal counseling and home visiting.

A CHILD LIFE PROGRAM IN ACTION

Child Life programs at the Children's Hospital of Eastern Ontario began three years ago at the same time the hospital was opened. A total of nine Child Life staff and more than 150 volunteers are involved in the various programs.

When children or adolescents are ill and hospitalized there is interference with the normal life activities which foster growth and development. There is also stress and anxiety concerned with illness and visits to the hospital. The aim of the Child Life programs is to minimize the traumatization of illness and hospitalization and to encourage the continued growth of the child or adolescent — physically, emotionally, intellectually and socially. The Child Life staff also aim to foster involvement in children's activities on the part of all who are in contact with the child and his family.

Some of the services and resources made available to patients at the CHEO include:

1. Infant program

Infants respond selectively to their environment and appropriate environmental stimulation during infancy is important for later cognitive growth as is the opportunity to play and explore. Physical activity such as rolling, crawling, standing, etc. lays the foundation for proper motor development.

The Child Life Worker acts as a comforter, a role model, and a teacher. She is concerned with the baby's sense of security, with the comfort of the parents so that their interaction with their baby remains as relaxed as possible and with the kinds of environmental stimuli available. Taking into consideration the baby's illness and treatment she tries to ensure continued developmental progress and to identify areas of developmental lag.

2. Preschool program

Monday — Friday 8:30 to 16:00 hours and Saturday 8:30 to 12:00 hours. A Child Life Worker visits children on a one-to-one basis and also runs a play program in the playroom on each unit. The playroom contains the familiar — toys. Children, parents and staff can play and learn together. The child can express his feelings and thus communicate through play as well as continue to learn and socialize. The staff can learn about motor or perceptual problems, language development, social skills and intellectual development. In the hospital environment play is crucial to the child's affective development. It is through play that tension is released and that fears may be expressed.

3. Schoolage program

Each unit has an activity room and a Child Life Worker. The forced dependency and restriction of freedom associated with illness and hospitalization is felt by all age groups but in the 7 to 12-year-old group it is often through choosing a project and completing it to one's satisfaction that self-esteem is kept intact. The children do pottery, macramé, leatherwork, weaving, Indian beading, etc. Games are often educational, diversional and socializing. Feelings are more easily expressed through a non-verbal media and it is necessary to become the child's friend before he will express his deepest fears. The Child Life Worker's report to the health care team may be in terms of the child's skills, fears or behavior as it is in the setting of the activity room or in a play situation that the child as a person becomes clearer.

4. Education program

Since most children over the age of five spend a large part of their week in school, consideration must be given to the fact that school is for most children a "normal life activity." Bilingual teachers are made available through the Ottawa Board of Education and their office is located on second floor in the Child Life area. The nursing and medical staff identify potential students, the nursing staff obtain signed consents for tuition from the attending physician and the parent and then notify the teacher. The teacher contacts the child's school so that the child will follow the same curriculum in the core subjects as the peer group to which he will return. Thus, it is hoped that a child hospitalized for any length of time will be only minimally behind as a result of having been away from school.

5. Youth Unit program

Hospitalization is particularly difficult for the teenager. What is happening to me? What is going to happen? How long do I have to be here? Am I going to get my credits this term? Why isn't my girlfriend/boyfriend visiting me? The adolescent wants to be kept informed and needs to understand his illness, treatment, prognosis. The Child Life Worker finds ways often through special projects, one-to-one conversation or games, or group activities and entertainment to help the teenager cope with his condition and hospitalization. It is sometimes necessary for the worker to interpret the adolescent's behavior to parents and staff. A weekly group meeting is held to facilitate patient-staff communication.

6. C.I.D.U., I.C.U. and Evening programs

One Child Life Worker is available to cover all of these areas. She is on the Clinical Investigation and Dialysis Unit on Monday and Friday 8:30 to 16:30 hours and Tuesday, Wednesday and Thursday from 13:00 to 17:00 hours. She also runs a Tuesday evening craft program, a Wednesday evening music or special project night and a Thursday games evening. I.C.U. is visited daily by this worker. Play serves an important expressive function in these areas where the tension of parents and children tends to be high. In the dialysis area the education program is especially important

since for the child dialysed on three school days a week, schooling takes place mainly in the hospital and the one-to-one tuition better enables remedial instruction to be carried out.

7. Kitchen program

Attached to the large activity room on the second floor is a non-institutional kitchen area. A dietitian (Food Service Department) plans "cooking is fun" activities for children of various age groups (parents may participate as always) and for groups with common dietary concerns. Parents cook for their children or have a family meal together with the doctor's consent. Often Mom's cooking is the stimulus to prompt a reluctant eater. There is resource material available through the Child Life office re the use of the kitchen by parents and staff to make cooking a fun and educational program. (Children learn math concepts, new words e.g. grate, sift, cream, and exercise motor skills).

8. Children's Library

The library on the second floor contains an excellent selection of English and French children's literature. It also serves as a classroom, a teacher's office, a meeting place for school tours and for the diabetic education/recreation program. Bookcart service manned by volunteers visits all units Monday-Friday and book returns are between 70-100 a day. The library contains the classics, current children's literature, books to help prepare children for hospital procedures and some reading material for parents. The library is an important resource to the teachers and students. The library is managed by the Child Life Department and clerical and bookcart service manned by Volunteer Services.

9. Outdoor facilities

These include a playdeck and a playground. The playdeck has vegetables and flower boxes and is used for infant sunning, an outing for children who need to be close to a unit for possible medical emergencies and for the preschool children on that floor.

Playground activities are compiled into a schedule and circulated by the Child Life Department. Children using the playground must be supervised by hospital personnel or parents, and medical and nursing permission is needed before inpatients can be involved in playground activities. Daily inpatient usage averages 12-16 inpatients per day and a daily average of 36 children (inpatients, outpatients, special groups).

10. Special entertainment

The Child Life Department works closely with the Community Relations Office and community groups that have undergone an initial screening process as to suitability of performance, length of performance, space required, etc. These groups are booked into the monthly program of activities which is circulated to all units. Community participation is particularly active at Christmas. We have enjoyed professional ballet, the National Arts Centre orchestra, children's theater and several amateur entertainment groups. The Ottawa School Board, the National Film Library, the Museum of Man, the Ottawa Public Library, all generously contribute to our educational/recreational programming.

11. Weekend programs

During the summer, weather permitting there are Saturday barbeques. The rest of the year a preschool program is provided Saturday morning and a schoolage program or feature film on Saturday afternoon.

Each Sunday the Christian Council of Churches sponsors a Friendship Hour. The Friendship Hour leader plays guitar and the children join in the action songs.

12. Inservice education and practicum placements

Nursing, education, dietetic and recreology students spend varying amounts of time in the Child Life Department. Workshops focused on therapeutic play or adjustment to hospital or specific craft demonstrations are held frequently but on a request basis.

13. Orientation

Pre-operative classes are given Tuesday in French and Thursday in English by the anesthetic nurse in the second floor activity room.

School tours organized by the Volunteer Department begin in the Child Life Library.

14. Outpatient program

The Child Life Worker's role on the diabetic team is to coordinate an education/recreation program every Tuesday 7:30-12:00 hours. This program consists of an exercise program followed by age suitable activities to help children learn about and cope with their diabetes.

Information concerning appropriateness of play materials and activities for specific age groups is available to volunteers and staff in the O.P.D. area through the Child Life Department.

15. Special projects

The department has a continuous supply of toys which are tested and evaluated for the Canadian Toy Testing Council.

One of the staff has rewritten the booklet for parents, "Your Child Goes to the Children's Hospital of Eastern Ontario."



COMMENTARY



Shirley Post

Children admitted to hospital are plunged into unfamiliar and frightening surroundings, separated from their family, and subjected to intrusive, often painful procedures. Without support and assistance in coping with the stress of these experiences, some of them are slow to recover, exhibit developmental regression, develop fears of abandonment and mutilation, or exhibit emotional problems at home and at school after they leave hospital.

Despite the fact that for the past twenty years we have had quantities of research and documentation regarding the emotional and developmental responses of children to illness and hospitalization, the policies, routines, and environments of many of our pediatric units have changed little in the last decade.

In 1975-76 as I travelled about Canada talking with persons about what they perceived to be problems and issues in child health that a national organization might address, the care of children in hospital was often raised as a concern. Parents in every province voiced unhappiness with the hospital arrangements for children in their communities. They took for granted that the technical and medical care was good but were often critical of visiting policies, the lack of facilities for parents to stay overnight, the inadequate information they received from medical and nursing staff, the lack of play facilities and the opportunity for a child to continue with his studies. In some hospitals children are still placed on adult wards where it seems to be even more difficult to meet their special needs.

It is evident that there is much to be done to improve the standards of care for children in hospital and the Canadian Institute of Child Health will be reviewing the situation. It is my hope that studies such as this will stimulate hospital boards and personnel to begin to question and review their policies in relation to the needs of hospitalized children and their families.

Many changes have been identified which could improve the hospitalization experience for children. Most of these do not require new legislation or large amounts of money but, rather, involve changes in attitudes, policies, and the recognition that we cannot model or transfer traditions and policies established for adult units to children's units. Children have special needs and problems that we must not continue to ignore. Some of these special needs are:

1. *Visiting*

An important change that is needed is complete elimination of restriction on parental visiting rights. Parents should be encouraged to feel they are important participants in the child's hospital care.

Not all mothers can or wish to stay overnight with their children, but the opportunity should be available. Some "live-in" facilities should be available for mothers especially those with infants or pre-school children.

2. *Play programs*

Physical activity is important to children and is essential that space, equipment and a program be provided. Someone must be assigned the responsibility of seeing that opportunities are available for the children paint, to play out their fantasies, to work ou tensions through motor activity, crafts and games. Play activities are not "just for fun," b provide learning and therapeutic experience for the hospitalized child and should be an integral part of an child's hospital experienc

3. *Schooling*

All hospitals should have written, agreed upo policies and procedures with the local school boards for the referral of children as soon as they are able to continue their studie in hospital.

4. *Information and Orientation*

Parents and child should be prepared for th hospitalization experience whenever possibl Pre-admission visits and books for parents read themselves or read to their child help them to understand what to expect. It shoul also be possible for them to have an admissio interview with the child's nurse which gives them an opportunity to ask questions and b involved in the plan of care for their child.

Where to from here?

The author of *"Hey, what about the kids?"* suggests that we need nurse advocates wh are fully convinced that pediatric care involves meeting the special needs of children and ar prepared to push for the necessary changes

I agree, and I believe that we have man informed nurses who have read some of th relevant literature and are aware of the man excellent programs that some hospitals have organized for children and their families. But, i is discouraging to discover that some nurses still regard parental visits, toys, schooling and explanations as "frills," or believe that they might be desirable but "it would be impossibl to have such a program here."

Some administrators are also reluctant t change. They are ready with a string of excuses such as "lack of space," "rigid nurses," "traditional doctors," "no money," "the children are not in hospital long enough."

Some doctors also feel that "this component of care has nothing to do with medical care," that "parents are a nuisance,

that "infection will result," and that these changes involve nursing and administration more than medicine.

It is apparent that before we get any action or change of attitudes in some hospital units, a *multidisciplinary* approach will be necessary.

In 1965 a group of Child Life Workers organized an international group to focus on the psychological and social aspects of care of hospitalized children and their families. This organization is called the Association for Care of Children in Hospital. They decided to open membership to *all professions* working within pediatric settings. They have representation from nursing, psychology, psychiatry, pediatrics, occupational and physiotherapy, recreation, education and administration. They hold an annual meeting and have a journal. About two hundred Canadians belong and affiliate groups have been organized in Manitoba, British Columbia, and Nova Scotia. Membership is available by writing A.C.C.H., P.O. Box H, Union, West Virginia, 24983.

If professional providers do not make some of the most urgent changes, then I believe that hospitals will be faced with parent groups demanding that these changes take place. Parents are also going to be asking why some children must be hospitalized at all; they will want to know why improved ambulatory services, day care and home care services are not available as alternatives to hospitalization.

There is much to be done. Many of us in the nursing profession are aware of the changes that must take place.

Let's get on with it.

Shirley Post *was a key figure in the establishment in July of this year of the Canadian Institute of Child Health, co-founded by the Hospital for Sick Children Foundation in Toronto and the Canadian Council on Children and Youth. Now Vice-president of the Institute, she was formerly Director of Nursing at the Children's Hospital of Eastern Ontario.*

Photos courtesy of Children's Hospital of Eastern Ontario





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What's New



Hospital Bed Shampooing Made Easier

Important as patients' appearance is in contributing to their well-being, shampooing and rinsing of hair has always presented a problem to hospital staff. "Comfort-Cleanse" is a new shampoo and rinse basin which not only works well but is comfortable when placed under a patient's head because it's soft and durable. The shampoo basin incorporates plastic liners which collect shampoo and rinse water and are disposable.

Because the basin material is of the soft "memory" type, it molds itself to the back of the patient's neck and forms a fluid-tight seal which prevents shampoo and rinse water from wetting patient's clothing or bed covers.

For information write: Oxford Enterprises, Inc., 333 North Michigan Avenue, Chicago, Illinois 60601.

Reference Chart for Emergencies

"Emergency Procedures for Dangerous Materials" is the title of a 35 by 45 inch washable reference chart. The chart lists many chemicals and describes how to store, handle and dispose of them. If these chemicals penetrate the skin, get in an eye, or are swallowed, a glance at the chart tells how to handle the situation.

Handy for shops, chemical plants, laboratories, safety departments, first aid rooms and hospitals, the chart is printed in large type, is color coded, and has metal mountings for hanging.

For information write: Safety Supply Company, 214 King Street East, Toronto, Ontario, M5A IJ8.

Dennison Stockinette

A sterile, tubular, unbleached stockinette from Dennison Manufacturing Company saves labor, time and cost by eliminating the need for hospital preparation. Patient safety is insured by the minimization of cross contamination caused by unnecessary handling.

The pre-cut, pre-sewn stockinette is made of 100 per cent long staple cotton. It is packed in a water-repellent pouch that is tear and puncture resistant, adding to its shelf life.

An innerwrap of Dennison Aqua-Plus, a non-woven, water-repellent, soft, drapable material insures sterility.

The rolled-to-size Dennison Stockinette comes in a variety of widths and lengths in single or double ply to accommodate a variety of orthopedic surgical requirements.

For information write: Dennison Manufacturing Company, Hospital Products Section, Specialty Products Group, Framingham, Massachusetts 01701.

Sniffle Free Land

Guinne's Sniffle Free Land provides children with a fun way to learn good health habits. Teaching basic hygiene is an important job for both teachers and parents. By presenting this information in game form, learning about good health habits is enjoyable for children.

The element of competition is challenging for children from 5 to 9 years of age. Did you wash your hands before breakfast? If yes, advance two spaces; if not, go back two spaces. Did you eat your breakfast today? If yes, advance two spaces and so on. Appropriate behaviors result in positive reinforcement and bad habits lead to negative reinforcement.

Sniffle Free Land helps to teach good hygiene and nutritional habits that are important to form at this stage of development. It also helps to promote honesty and self-evaluation.

Sniffle Free Land is available for $6.95 plus $1.00 postage from Guinne's Games Inc., 1717 Penn Avenue, Scranton, Pennsylvania 18509.

Maddak Hand Gym

Daily use of the Maddak Hand Gym has proved in actual testing to improve muscle strength, range of joint motion and useful hand function in a majority of rheumatoid arthritis and osteoarthritis patients.

According to the Arthritis Foundation, there are five million Americans with rheumatoid arthritis serious enough to require medical care. When this disease affects the joints of the hand particularly the big knuckle joints, it often leads to muscle imbalance and abnormal push and pull of ligaments and tendons. This can cause dislocation of the big knuckle joints, sideways twisting of the hand and fingers, and deformities which make normal use of the hand difficult or impossible. Quite aside from the severe pain that accompanies joint inflammation, this can have a shattering effect on the daily lives of the victim.

Arthritis experts have long known that special exercises to strengthen weakened muscles and maintain normal range of motion are essential to effective arthritis treatment. Usually complex hand exercises require the help of a physical therapist. But the Hand Gym is designed to make appropriate finger and hand exercises, both passive and resistive, possible without the help of another person.

It is also contrived to keep the big knuckle joints in an extended position — the so-called "protective hand position." When a rheumatic hand is used functionally, keeping it in this position helps prevent further damaging stresses, deformities and pain.

The Hand Gym is a three-dimensional triangular device of transparent plastic sheets with slots for the fingers, an adjustable "hand rest bar," exercise bars and elastic bands. The Gym permits a variety of finger and thumb resistive and non-resistive movements. Patients get detailed exercise instructions to achieve specific goals, such as improving agility, dexterity, flexibility, muscle strengthening, etc.

For further information contact: Maddak Inc., Pequannock, New Jersey 07440 U.S.A.

Serving Tray

A new serving tray has been introduced for use with the Stretcha patient transfer device. This whole grained hardwood tray is stain-resistant and features a retaining lip. In addition, the tray eas and rigidly attaches into the arm support holes on the Stretchair.

The new product provides a convenient surface for reading, writing, eating, and playing games The tray also serves as a safety feature which helps support seriou injured patients.

Stretchair is a new patient transfer system from Mobilizer whi converts into a wheelchair or stretcher.

For additional information, writ Mobilizer Medical Products, P.O. B 147, Summit, New Jersey 07901.



Disposable Electrodes

Dispoz-It Disposable Electrode are pre-gelled with a specially formulated adhesive gel combinati specifically designed for routine EK in EKG Labs, doctors' offices, Emergency Rooms and Paramedic Units. Because there is no need to apply gel and no cleanup required afterwards, they are both labor an cost saving.

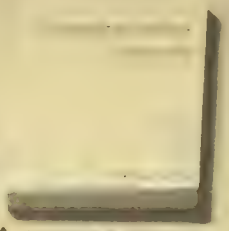
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For further information, write: MI Systems, Inc., 782 Burr Oak Drive, Westmont, IL 60559.

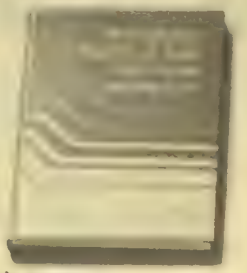
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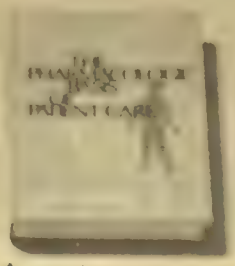
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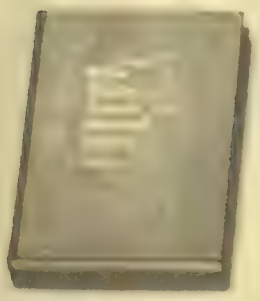
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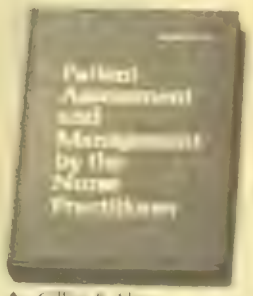
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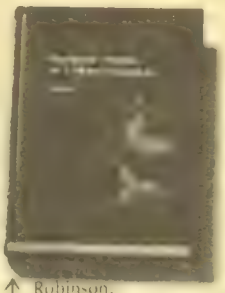
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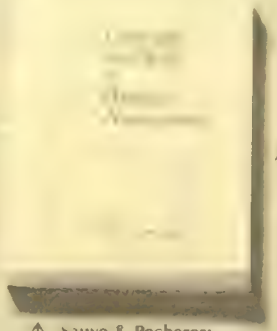
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Names and Faces

CNJ talks to ... Glenna Rowsell

This September, Glenna Rowsell assumed the new position of director of Labor Relations Services at CNA House in Ottawa, bringing with her a wealth of experience in nursing service and education, and especially in the field of collective bargaining in nursing.



Glenna has been involved in collective bargaining in nursing since its infancy, and says "now that it is an established fact, we have a whole new set of problems that must be dealt with."

An important function of CNA's Labor Relations Services will lie in the collection and analysis of data on collective bargaining throughout Canada bringing together the available material across the country.

In addition to building up these resources, Glenna will be involved in establishing communication lines, building a working relationship between CNA and provincial professional organizations and collective bargaining units, and establishing a much needed educational program about collective bargaining in nursing.

Glenna sees the educational component of the services to be provided as very important. Programs are to be developed on regional, provincial and national levels, for union members, professional associations, and for those who represent the management side of the bargaining table. Another important and necessary task will be that of fostering communication in each province between professional associations and collective bargaining units, now that the two are distinctly separate units.

Glenna comes to CNA House from Fredericton, where she was employment relations officer for New Brunswick's Provincial Collective Bargaining Council and consultant in social and economic welfare for the New Brunswick Association of Registered Nurses. But she is no stranger to Ottawa, having worked with CNA from 1961 to 1966 as director of CNA's school improvement program and from 1966 to 1969 as consultant in social and economic welfare.

Glenna's post as director of Labor Relations Services is already proving a welcome one. After only a week in Ottawa, she remarked, "Since I moved into my office here, my phone just hasn't stopped ringing. It's just like home."

Laura W. Barr, past executive director of the Registered Nurses Association of Ontario has been appointed assistant executive director of patient services at Sunnybrook Medical Centre, University of Toronto. The appointment was effective August 1, 1977. In her new position, she will have direct responsibility for professional services related to the hospital's patient care program.

In addition to her fifteen years at the RNAO, Barr has served on various academic and health care committees, including the recent Ontario Council of Health task force on the 'Distribution of Beds in Hospitals and Nursing Homes in Metropolitan Toronto.' In April 1977, she was appointed by order-in-council to the Ontario Mental Health Foundation.

Gayle Biette, a member of the RNAO Eastern Chapter, received the Lillian Campion Award from RNAO Foundation President, Laura W. Barr. Mrs. W. Foukes, a member of the Campion family, also attended the ceremony.

Biette is on leave of absence from her position with the Toronto Department of Public Health while completing a graduate program leading to an M.Sc.N. degree.



A. Judith Prowse has recently been appointed chairman of the Health Sciences Department, Grant MacEwan Community College in Edmonton, Alberta.

Having received a B.Sc.N. from the University of Alberta, Prowse taught pediatrics and behavioral sciences at the Medicine Hat General Hospital School of Nursing. This was followed by clinical supervision in pediatrics and then surgical nursing at the Royal Alexandra Hospital, where more recently, she was Director of Inservice Education. A past president of the A.A.R.N., she has been actively involved in her professional association at provincial and national levels. She is currently completing her Master's in Health Services Administration at the University of Alberta.

Prowse will succeed **Sister T. Castonguay** who has been with the College since its opening in 1971.

Arlene Draffin Jones, Patient and Family Education Nurse at the Respiratory Centre, Health Sciences Centre, Winnipeg, Manitoba, has been named chairperson of the Canadian Tuberculosis and Respiratory Disease Association Nurses' Section. She succeeds Dr. Shirley Alcoe of Fredericton.

Jones, a graduate of the Salvation Army Grace Hospital School of Nursing in Winnipeg, received her B.Sc.N. from Lakehead University in Thunder Bay, Ontario. She has had experience as a staff nurse in a wide variety of clinical settings and has also worked as a clinical instructor.

Jones is past chairperson of the Respiratory Interest Group of the Manitoba Lung Association.

Angela Kucinskas, R.N. of Toronto Ontario and **Gayle MacIntyre,** R.N. o New Westminster, B.C. have been awarded the Judy Hill Memorial Scholarship for 1977. Both nurses w use the $2,000 scholarship to study midwifery in Britian and will then retur to serve in northern Canadian nursin stations. This marks the first time tha two scholarships have been awarde

The memorial scholarship is awarded each year to commemora Judy Hill, a nurse who died while serving in northern Canada.

Joan Mills has been appointed Executive Secretary of the Registere Nurses Association of Nova Scotia effective Sept. 15, 1977. She succeeds Frances Moss.

Mills is a graduate of the Halifa Infirmary School of Nursing and obtained her B.Sc.N. at St. Francis Xavier University. She has worked both as a staff nurse and as an instructor. For the past ten years, sh has been a faculty member of the department of nursing of St. Franci Xavier University teaching "Nursing the Adult."

RNAO Fellowships have been awarded to two RNAO members: **Marjorie Wallington** (R.N., Oshaw General Hospital, B.Sc.N., Universi of Western Ontario; M.Sc.N., Bosto University) who plans to attend the Catholic University of America in Washington, D.C. to pursue study towards a degree in Doctor of Nursir Science in Mental Health/Psychiatr Nursing. She plans to return to Lakehead University in Thunder Ba Ontario where she is an assistant professor.

Carol Woods (B.Sc.N., Lakehead University) is a lecturer in medical-surgical nursing at Lakehea University. She is enrolled at the University of Toronto in the Master Science in Nursing Program where she will pursue her interest in medic surgical nursing. On completion of h degree, she plans to teach nursing and to provide direct patient care as clinical nurse specialist.

New Appointments

Ruth Mellor has been appointed Regional Director for Ontario of the Victoria Order of Nurses for Canada. She takes over from **Catherine Maddaford** who retired June 30 after a distinguished career with the VON.

Sheila Ryan (B.Sc.N., M.H.S.A., University of Alberta) has resigned her position as Associate Vice-President (Nursing) at the University of Alberta Hospital in Edmonton to take up the position of Director of Nursing, University of British Columbia Medical Centre, Department of Psychiatry.

In the past, Ryan has served on several AARN committees, on the board of the Victorian Order of Nurses and on the Manpower for Mental Health Education and Training Study Group for the Report on Alberta Mental Health, 1968.

The Jewish Convalescent Hospital in Chomedey, Laval, Quebec has announced the appointment of **Bonnie Lee Smith** (R.N., B.Sc.N.) as director of nursing. Prior to this appointment, Smith was employed at the Montreal General Hospital as a head nurse. She has also had extensive teaching experience both in Quebec and in Ontario.

Jean Murdoch (R.N., St. Martha's Hospital, Antigonish, N.S.; B.Sc., St. Francis Xavier University) has been appointed director of the school of nursing at the Halifax Infirmary, Halifax, N.S.

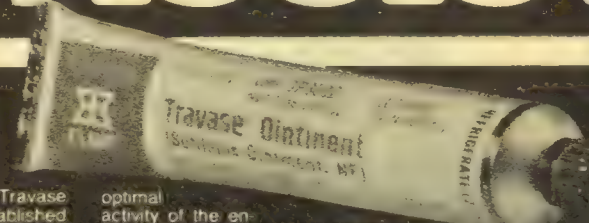
Murdoch has been director of nursing at Hôpital Des Sept Iles, Sept Iles, Quebec and director of nursing education at Jeffery Hale's Hospital in Quebec City. Currently, she is a member of the Corporation of Nurses of Quebec's Education Committee and is the first vice-president of the provincial committee of directors of nursing.

George Bergeron has been appointed the new liaison officer for the New Brunswick Association of Registered Nurses. A former newspaper reporter, photographer and editor, Bergeron is a graduate of Carleton University in Ottawa. He replaces **Nancy Rideout** who has been NBARN's liaison officer for nearly ten years.

Marvin M. Burke, executive director of the Nova Scotia Commission on Drug Dependency is the new president of the Canadian Addictions Foundation (CAF) formerly the Canadian Foundation on Alcohol and Drug Dependencies.

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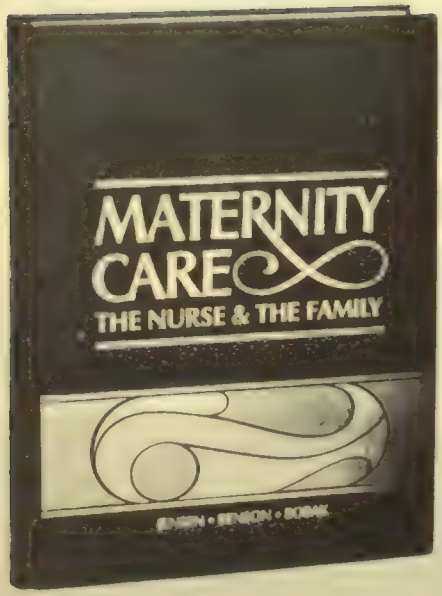
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By Margaret Duncan Jensen, R.N., M.S.; Ralph C. Benson, M.D.; and Irene M. Bobak, R.N., M.S.; with 2 contributors. April, 1977. 764 pages plus FM I-XX, 8½" × 11", 684 illustrations. Price, $18.40.

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New 2nd Edition! **BEHAVIOR MODIFICATION AND THE NURSING PROCESS.** By Rosemarian Berni, R.N., M.N. and Wilbert E. Fordyce, Ph.D. This new edition presents practical up-to-date guidelines to help nurses apply behavioral methods to many specific patient management problems. Focusing on contingency management or operant conditioning, the book examines such topics as: increasing or decreasing behaviors, pinpointing targets, reinforcers, systems implementation and evaluation. Extensively revised and expanded, this 2nd edition features many additional practice and demonstration problems. May, 1977. 176 pp., 10 illus. Price, $6.05

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Research

- **Consumer Rights**

Consumer Rights and Nursing. Edmonton, Alberta, 1977. Thesis (Master of Health Services Administration), University of Alberta by *Janet L. Storch.*

The purpose of this study was to provide a background study for the use of nurses, and other health professionals, in examining consumer rights in health care.

Seven major societal changes, identified by Roland Warren, were employed as the basis for analyzing changes in society, in health care organization and in nursing. Reactions to these societal changes, including growth of human rights concerns, with particular reference to Canada; the emergence of a new consumerism; and the refinement of community development processes were examined.

Consumer rights issues in health care were examined as part of the same reaction to change, this time related to the health care system. The right to information, the right to respect, the right to participate, and the right to equal access to health care were discussed as the central concerns in consumer rights. The role and function of the patient representative, a new worker in health care, was compared and contrasted to the role and function of the legislative ombudsman.

A brief analysis of nursing, past and present, discloses both areas of strength and areas of weakness affecting nursing's ability to be responsive to consumer rights in health care. While nursing has evidenced considerable interest in consumer rights issues, it would seem that nursing has been almost immobilized in acting on these concerns by an inability to grapple with the problems of nursing itself.

It was concluded that nursing must strive to overcome the problems within nursing, reassume a vital role in consumer advocacy, and above all implement consumer rights in health care and in nursing. Failure to act is to jeopardize the consumer's realization of his rights in health care, and to jeopardize the future development of nursing.

- **Nursing Practice**

The Practice Environment as Perceived by New Graduate Nurses. Nursing research conducted at the Sunnybrook Medical Centre, Toronto by *Gloria Kay,(M.Sc.N.).*



This is a descriptive-comparative study of 134 (2 groups of 67) newly graduated nurses, who began practice as general staff nurses in a university medical center in the summer-fall period of two consecutive years. It was hypothesized that factors promoting job satisfaction/ dissatisfaction would retain consistency in content and importance for neophyte nurses despite differences in staffing ratios and changed economic conditions; and that interpersonal relationships at the patient care level would be a more important factor than the literature indicated. Data supported these predictions.

Collected by questionnaire completed on termination of a 60-worked-days probation period, findings are compared for both groups under (1) characteristics of the nurse as a person; (2) factors influencing job seeking and acceptance; and (3) new graduates' perceptions of: job environment, patient care, impediments to practice, her competence, her needs and problems, and satisfying and dissatisfying aspects of practice.

Recommendations focus on the needs for (1) realistic molding of student nurse expectations of practice as well as competence through changes in education; (2) assessment, clarification, and collaboration by service agencies concerning their patient care tasks and problems; and (3) the responsibility and opportunity afforded the organized profession to orchestrate the needs of patient, employer, and practitioner to meet the humanistic goals of all concerned.

- **Education**

Education in Health Care in an Intercultural Maternity Service. Edmonton, Alberta, 1977. Thesis (M.Ed. in Anthropology and Intercultural Education), University of Alberta by *Emma Nemetz.*

Health care provided by the modern medical establishment includes education of clients, concommitant with the change —disease, trauma or condition — which dictates treatment. Expertise in providing such education is based upon education of the health care worker in both medical and extra-medical domains of knowledge, definitive of a knowledge-oriented work community.

This study is an exploration of several educational aspects of the health care of maternity patients in a Canadian hospital which serves a population of both native and non-native clients. Interviews with health care workers document a difference between natives and non-natives as perceived by those health care workers. The specific differences are categorized and data gathered through participant-observation in the hospital is compared to the health-care workers' perceptions, using several variables in ante, peri and postnatal care and education.

It was found that differences exist, both in native and non-native response to the treatment surrounding maternity health care, and in the workers' interactions with clients, based on the workers' apparent definitions of a native/non-native distinction. The findings reflect a need for a better definition of such differences, where they in fact exist, and for subsequent improvement in the education of health-care workers.

- **Pediatrics**

Early Identification of Developmental Impairments in Infants Birth to Nine Months of Age. Vancouver, B.C. Thesis (M.Sc.N.) by *M. Grace Doherty.*

Early recognition of real or potential developmental impairments in infants is an important public health role. This experimental study was undertaken to determine the effectiveness of scheduled nursing assessments of growth, development, vision, hearing and nutrition from birth to nine months of age. A secondary purpose was to determine the predictive validity of currently used pregnancy and infant profiles for subsequent developmental impairment.

The null hypotheses tested were:
I. That the scheduled community health nursing assessments between birth and nine months of age will not detect any developmental impairments which have not already been detected by existing health services.
II. That there is no significant difference in the number of developmental impairments detected at nine months of age, between a group of infants screened by the proposed schedule of assessments and a group not so screened.
III. That there is no significant difference in the number of children exhibiting developmental impairments by nine months of age, between a group of "at risk" and a group of not "at risk" infants, using the criteria from the Vancouver Health Department's Pregnancy Profile and Infant Profile At Risk Criteria.

After a study of 100 infants from one health unit area who were alternately assigned to an experimental and a control group, the findings supported scheduled community health nursing assessments of infants from birth to nine months of age. The pregnancy and infant profiles were found to be sensitive but not specific tools for prediction of subsequent developmental impairment. The three null hypotheses were rejected.

Implications for nursing practice are discussed and recommendations for further research suggested.

Books

Love, sex and sex roles by Constantina Safilios-Rothschild, Englewood Cliffs, N.J., Prentice-Hall, 1977.
Approximate price $8.95
Reviewed by Sharon Turnbull, Assistant Professor, School of Nursing, University of British Columbia, Vancouver, B.C.

Those who seek answers to the "many profound and difficult dilemmas" of sexual relationships and love will not necessarily find them in this book, but many of the issues raised by the authors are issues of significance to the health professional. Rapid changes in social and cultural values tax the ability of man to adapt or even to cope. The nurse can benefit considerably from the author's delineation of many of the binds we face in today's society.

The major thesis of this book is that changes that would eliminate social inequalities and sex-role stereotyping should create a milieu conducive to supportive, game-free loving and and sexual expression. The author brings the sociologist's perspective to a cross cultural analysis of love, sex, and gender in order to identify and define the problems we face. The enormous task of defining and analyzing the vast realm of human experience in sex and loving must tax the limits of any singular discipline, and what is missing in this analysis is the richness of psychological theorizing, historical analysis and literary illumination. Recognizing these limitations, the reader may find this book a stimulus for thought, discussion and clarification of values. Therein lies its greatest value.

The author must be commended for the serious consideration she gives to the problems faced by the male of our species, a lamentable deficiency in most writings that promote social equality. Unfortunately, her analysis of problems as they affect different age groups is somewhat superficial.

In the reviewer's opinion, two major deficiencies are apparent in this book. The author, while recognizing the difficulties inherent in developing an adequate definition of love, offers a rather weak operational definition. For example one of the elements she includes is "the willingness to please and accommodate the other even if this entails compromises and sacrifices." She says in following that if this element is not present to "any degree and intensity" the relationship is apt to be exploitative, but it is often argued that it is the existence of just such an element that encourages exploitation. Her further categorization of types of love is helpful as it applies to the traditional male-female lovers context but does not address aspects such as parental love, homosexual love or the love of friends. Perhaps a broader perspective would have contributed more to an understanding of the topic.

The major weakness, however, is the statement of the author's conclusions which are not always adequately supported by the data she presents, are contradictory, or which are not based on sound logic. For example, the author states that women have "not particularly valued" the friendships of other women "because of the prevailing notion that women are less valuable than men." No data are given to support this claim that women do not value these friendships, and no effort is made to substantiate a causal relationship.

In her discussion on humanizing sex and love, the author offers a prediction that men will no longer "judge, appreciate and be attracted to women primarily in terms of their physical appearance" and will instead desire women who are "competent and intelligent" or "financially and/or occupationally successful." Undoubtedly, we pay the high costs the author describes for over-valuing the fleeting and often unattainable goal of feminine beauty, but wouldn't another caste of unloveables (e.g. the unintelligent and incompetent) be created if such a shift in values were to occur? These sorts of premature generalizations suggest that some rather strong biases were at work.

This book covers ground that is familiar to anyone who has read seriously in this area, but is thought provoking. It presents a challenge to consider the frontiers and the limits of some important human relationships and in so doing merits our attention. While it fails to offer any new or definitive answers to the profound and difficult dilemmas, it does accomplish something that may be much more important: it identifies the questions. For as a great wit once said, "Love may be the answer, but what is the question?"

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The Expanded Family: Childbearing by Carole L. Blair and Elizabeth M. Salerno. 261 pages. Boston, Little, Brown and Co. 1976.
Approximate price $8.95.
Reviewed by Margaret Richardson, Nurse Clinician, The Moncton Hospital, Moncton, N.B.

This book, written by two nurses, is divided into two parts. Section One presents an innovative approach to the fundamentals of nursing practice. Although the title may mislead some who are not interested in obstetrics, this section would be beneficial and worthwhile in medical-surgical nursing, or in any other milieu. The approach used broadens the nurse's perspectives of the patient and summarizes experiences. It also relates theory and knowledge to patient settings.

The book is concise, easy to read and contains categorized assessments of situations encountered in nursing.

Section Two of the book, relates the "tables" presented to the childbearing process, but they could also be related to any individual life event or illness.

This book should prove useful to both undergraduate and post-graduate nurses.

Nursing care of the growing family; a maternal-newborn text by Adele Pillitteri. Boston, Little, Brown and Co., 1976.
Approximate price $15.00
Reviewed by Marilyn Andrews, Maternal-Child Instructor, General Hospital, St. John's, Newfoundland.

"Nursing Care of the Growing Family" is a text designed to cover the nursing care of the mother and family from the time of diagnosis of pregnancy to the child's first weeks.

The book has seven chapters, beginning with prenatal care and progressing through labor and delivery, and dealing with the postpartum period and the newborn. The last two chapters discuss the high risk pregnancy and the high risk infant.

I found that the chapters of this book are outlined clearly and concisely, and the pictues and diagrams are excellent. The reference lists at the end of the chapters are detailed and comprehensive.

I feel that this text covers the theory and the psychosocial aspects of nursing quite well. I like the fact that it discusses the needs of the whole family (i.e. the father's and sibling's role), while considering the mother and child. This is a necessity today when our health care and our educational systems are family life centered.

I feel that this book would be useful to a student as an adjunct to her prescribed texts. Nursing personnel in clinical areas should also find this book helpful for quick reference.

Books

The Pediatric Nurse Practitioner; Guidelines for Practice, 2ed, by Fernando DeCastro et al..., 211 pages, St. Louis, The C.V. Mosby Company.
Approximate price $6.85.
Reviewed by Julia A. Shea, nurse practitioner and head nurse — Medical Specialties — Ambulatory Services, The Hospital for Sick Children, Toronto, Ontario.

The second edition of this book contains thirty-two chapters and is divided into four thematic sections: 1. introduction 2. health appraisal 3. clinical problems 4. the child and the family in society. It is a comprehensive reference text for all nurses practicing in expanded roles; its emphasis is on the actual practice of nursing in a pediatric setting.

Chapter two features three guest authors, all nurses, who present the various aspects of the role of the nurse as a pediatric nurse practitioner from the American point of view. Chapter three features yet another guest author, whose concern is with the nurses' role in working with parents to promote the well-being of children.

Section two on health appraisal has been re-organized and updated since the first edition appeared in 1972; it includes the same clear black-and-white drawings that appeared in the first volume, plus a fold-out Denver Developmental Screening Test for growth and development in chapter seven.

In Clinical Problems in section three, two new chapters have been added on neonatal and parasitic diseases.

The concluding section entitled "The Child and the Family in Society" was called "Social Problems" in the book's first edition. Chapter twenty-eight deals briefly with the psychodynamics in childhood and touches on the subjects of temper tantrums, masturbation, nail-biting, etc. In Chapter thirty-two — a final guest author offers an overview of the role of the nurse as a pediatric nurse practitioner in the chronic care setting.

A well annotated bibliography appears at the conclusion of each chapter, and offers the reader a wealth of resource material for future reference.

This book will prove invaluable to clinicians practicing in varied settings, nursing students looking to a career in pediatrics, and anyone interested in updating their knowledge of normal pediatrics as it relates to nursing practice.

Emotional Care of the Facially Burned and Disfigured, by Norman R. Bernstein, Boston, Little, Brown and Co., 1976.
Approximate price $12.50.
Reviewed by Ann G. Staley, Head Nurse, Burn Unit, Vancouver General Hospital, Vancouver, British Columbia.

I do not believe anyone can experience the total impact of the social, psychological, economic, and physical devastation of a severe burn unless they are directly involved. Let's hope through Norman Bernstein's compassionate book *Emotional Care of the Facially Burned and Disfigured* that all members of the burn team and medical profession will have more insight into the severe psychological trauma of burn victims.

Dr. Bernstein points out the social importance of beauty and body image, our repulsion from ugliness, and our fear of the facially scarred. He writes of "social death" of patients who cut themselves off from medical contacts and friends, withdrawing from the world to become shut-ins.

Today through greater education and exchange of ideas and thoughts, we can learn as professionals to understand and accept such traumatic injuries and try to meet the needs of the patient and his relatives.

Case histories of both patients and relatives in Dr. Bernstein's book are excellent examples of "listening" to ways in which all levels of personnel can be more helpful and compassionate in their care.

Nursing staff, who are the most involved in direct personal care, give the greatest percentage of time to burn patients in treatments, teaching, and emotional support. Therefore nursing personnel should understand the mechanisms of psychosocial responses in their patients as well as in themselves.

A very important aspect of attitude in inexperienced nursing personnel can be manifested through nightmares, anxiety and feelings of incompetence. These are not uncommon in the first few months of working on a burn unit. Nursing staff should be able to discuss these feelings and be made aware that they will probably have them until a more mature level of confidence is attained. Had I read Dr. Bernstein's book a few years ago I know I would have found it extremely valuable.

Through reconstructive plastic surgery, planned social and physical rehabilitation, Jobst pressure garments, and a tremendous amount of caring and understanding, I hope our determination will eliminate some of the anguish and emotional scarring inflicted upon our patients.

My only criticism of Dr. Bernstein's book is I would like to have seen more follow-through photographs of the pictures shown.

The book touches many pertinent areas:

- the concept of appearance and society's reactions to the "normal" and the disfigured
- ways of coping with major changes in body image and self representation
- responses to disfigurement according to age.
- psychiatric care of the burned patient
- burn care personnel and their attitudes
- the burn patient in the family
- routes to rehabilitation.

I would suggest this book should be read by all members of the burn care team, especially burn clinicians, head nurses, and post-graduate nurses specializing in psychiatry or specialized trauma units.

May I also suggest we follow the author's guidelines for more effective and comprehensive care.

Human Development by Grace J. Craig. 497 pages. Englewood Cliffs, New Jersey, Prentice-Hall, 1976.
Approximate price $12.95.
Reviewed by Jane Wilson, Richmond Hill, Ontario.

Another general growth and development tex — how could it differ significantly from others? The author proposes to depart from the conventiona texts in two ways: firstly, the presentation of diverse concepts regarding the human lifespan; and secondly, the discussion of current issues relating tc various stages of development, for example, genetic counselling, early education, intelligence testing, youth culture, "middle life crisis," retirement. I car see the need for frequent revisions of the book as current issues change.

The first section is devoted to an overview of various theories of development and a review of the

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biological, cognitive, social and emotional aspects of development. This section takes up about one quarter of the total text. The remainder of the book follows the human lifespan, referring frequently to issues and pertinent research. My only disappointment with the content is the small proportion devoted to middle age and old age, a shortcoming I have noticed in other texts used for education of nurses.

The format of the chapters is easy to follow; topic and subtopic headings are printed in the margin for quick reference. However, lines drawn across the page between topics are distracting. The photographs, all black-and-white or brown-and-white, are often fuzzy or too dark. Diagrams and charts are clear and useful. The review questions are disappointing in that they ask for verbatim repetition, only occasionally drawing from the reader's experiences. Each chapter ends with a short annotated list of suggested readings. Annotation in the extensive bibliography as well would have been useful.

The subject material is concentrated throughout; there is much essential information per page. Supplementary readings would be necessary to give interest and depth to the subject. I cannot see the use of this book for a short overview course in human development. However, it would be a well-organized reference for these programs, and an excellent basic text for in-depth studies.

Management of Hospitals by Rockwell Schultz and Alton C. Johnson. Scarborough, McGraw-Hill Ryerson, 1976.
Approximate price $14.25.
Reviewed by Janet Moore, Assistant Professor, Faculty of Nursing, University of Calgary, Calgary, Alberta.

"Management of Hospitals" by Schultz and Johnson of the University of Wisconsin, Madison, was designed for individuals involved in the administration of hospitals, including medical and nursing personnel, other professionals, staff specialists, and department heads. In organization the book uses a systems approach, focusing on the health spectrum, hospital programs and staff, transformation of inputs into outputs, and environmental influences and constraints.

Part One considers the hospital as a subsystem of the health care system. It sees the hospital as the center of the health care system but suggests that although it may be the center for treatment of the sick and injured, most communities could play a larger role in improving health.

Part Two describes the hospital as a system composed of medical staff, nursing, and other services, and the coordination of these services with governing boards, administrators, and functional specialists. These elements, together with patients and their problems are inputs into the system. The hospital must provide high-quality and efficient service in order to transform the ill patient into one on the road to recovery. This is the output.

Part Three examines the transformation of inputs to outputs through management of quality, management of costs, and management of conflict.

Part Four considers environmental influences and constraints. Collective bargaining is discussed as an important environmental influence effecting the internal operation of the hospital. External influences on the regulation of hospitals is considered. A look to the future suggests environmental changes that may have an influence on hospital management.

This book could be suggested as a reference for nursing faculty, as well as those nurses involved in nursing administration. This is an organized resource book, collating current thinking and research in the administration of health care institutions.

Geriatric Nursing by Alison Storrs, 220 pages, London, Ballière, Tindall, 1976.
Approximate price $1.60.
Reviewed by Donna Hinde, Instructor, Division of Nursing, Mount Royal College, Calgary, Alberta.

This book presents practical information which serves as a useful guide to geriatric nursing care.

It begins with a general discussion of several modes of health care delivery for the elderly in Great Britain. These include the use of day hospitals, holiday beds (which allow families to have elderly members admitted to hospital for short periods), specialized treatment units such as geriatric orthopedic wards, and of course, general geriatric care nursing units.

The book goes on to discuss care of the elderly in any setting, including assessment of common health problems and diseases. The author emphasizes preventive care for the elderly. Such concerns as prevention of skin breakdown are discussed as integral to good nursing care of the elderly.

The problems of proper nutrition are covered in depth and include information concerning special needs of the elderly regarding diet.

A chapter on the incontinent patient emphasizes the importance of patience and understanding on the part of all staff in dealing with this problem. Incontinence is categorized according to cause; various practical approaches are presented which can be used to deal with each situation.

Of particular significance is the fact that the author stresses careful medication of the elderly several times throughout the book. The problems of overmedication are considered. The author emphasizes careful administration of drugs and observation of effects of the drugs on the patient. The author points out that nurses must recognize that the aging body does not metabolize and excrete drugs very well and thus drug toxicity is a common problem in the elderly.

One chapter is entitled "Mental Disease" and includes discussion of several diseases which cause behavioral changes in the elderly (e.g. Stroke, Chronic Brain Syndrome). Perhaps one disadvantage of the book is that it attempts to label most emotional reactions (e.g. Anxiety State, Depression, Mania), an approach that does not give much regard to the fact that the elderly often suffer what appears to be mental or behavioral changes due to isolation, sensory deprivation and loneliness. The nursing role in dealing with such behavioral problems could be more comprehensive, for it is in this area that the nurse often needs assistance to give helpful rehabilitative care to the elderly.

The author emphasizes that geriatric nursing is not for everyone. She points out that the rewards of geriatric nursing are much different than those of acute care nursing. In discussing the long-term geriatric patient, she discusses feelings nurses may have when caring for an elderly patient who seems to make little or no progress in the terms that we measure medical progress, i.e. "getting better." However, the discussion includes a positive approach to nursing the long-term patient which looks at him as a human being.

In summary, the book is a helpful digest of information for nurses caring for elderly patients. It uses a direct, realistic approach to patient problems. It is easy to read and can be read in a short time in its entirety, or chapters can be identified for quick reference about a particular problem. Its concise direct approach makes it a useful book for all levels of staff caring for geriatric patients.

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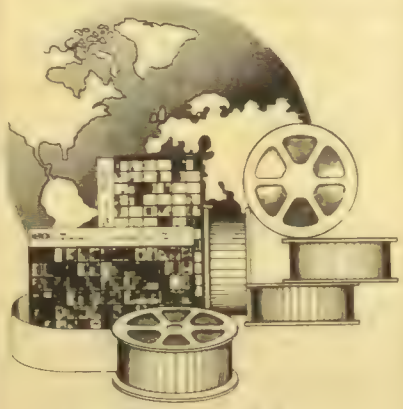
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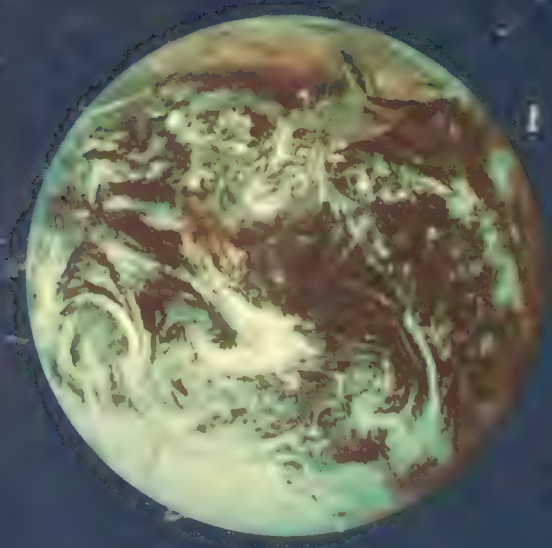
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December 1977

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the canadian nurse

December, 1977

The official journal of the Canadian Nurses Association published monthly in French and English editions.

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The winter woods are full of Christmas trees, and all December stars are Christmas stars. Our December **cover photo** is courtesy of National Film Board of Canada, Photothèque.

The views expressed in the articles are those of the authors and do not necessarily represent the policies of the Canadian Nurses Association.

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Herein



Tinker, tailor, soldier, sailor ... what made you decide to become a nurse? Most of us, according to manpower experts, just sort of slide into a career — or out of it, as the case may be. Two professors at the University of New Brunswick, however, decided last year to take a closer look at why young people in that province were deciding to enter nursing. The story about what they found begins on page 30 of this issue.

In the past five years, McMaster University Medical Centre in Hamilton, Ontario has developed a different approach to the head nurse role. People there have successfully combined the traditional roles of head nurse and supervisor to create a "middle manager," known as the Patient Care Coordinator. **Next month,** author Aileen McPhail describes the McMaster set up, the job of the middle manager , and how it all works. As well, four PCC's talk about their new role.

Life and death is what nursing is all about so it's not surprising that the one question that sooner or later every nurse must face is her legal and ethical involvement with a patient who is terminally ill. Next month, author Gilbert Sharpe, legal counsel for the Ontario Ministry of Health, shares his ideas about euthanasia, living wills and the legal responsibility of health professionals in **"Listening for the death-bells."**

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By **Beverly Witter DuGas,** RN, MN, EdD, Health Science Educator, Pan American Health Organization, Barbados, 686 pp. 218 ill. $14.25. June 1977. **Order #3226-2.**

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By **Joan Luckmann,** RN, BS, MA; and **Karen Creason Sorensen,** RN, BS, MN, 1634 pp., 422 ill. $23.95. Sept. 1974. **Order #5805-9.**

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By **Mary Jane Sauvé,** RN, BSN, MSN, Asst. Prof. of Nursing, Calif. State College, Sonoma, Rohnert Park; and **Angela R. Pecherer,** RN, BSN, MSN, Asst. Prof of Nursing Education, Intercollegiate Center for Nursing Education, Spokane, Wash. 427 pp. Soft cover. $12.05. Feb. 1977.
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Input

Babel revisited

I want to comment on Mohamed Rajabally's article (Frankly Speaking, September 1977).

Mr. Rajabally seems to find it dishonest to dress up the problem-solving approach and "call it the nursing process in an attempt to make it unique to nursing." To my knowledge no nurse educator wants to make it unique to nursing but rather to *apply* it to nursing. Mr. Rajabally laments that "students lose valuable time trying to learn something that they ought to know." Perhaps they *ought* to know the problem-solving approach but suppose they *don't?* And assuming that they do know it and use it intuitively, will they necessarily apply it to their work with a client?

I agree with him that nurse educators should be concerned with accountability. I do not, however, see accountability as incompatible with a solid scientific basis for practice. Looking at a theoretical foundation is not done "instead of better nursing care" but rather to lead to improved practice.

Mr. Rajabally sees a conceptual framework in fashion today, as rock and roll was in vogue in the Fifties. It is my contention that nursing programs have *always* been founded on some conceptual framework. Whether or not that term was used, and whether or not the theoretical foundation was solid or shaky, confused or clear, programs in schools of nursing were built on *something.* Mr. Rajabally quotes Edith Lewis' description of the confusion introduced by "all those little arrows." In the same editorial Lewis states that "not all models, of course, are pictorial;" she also acknowledges the usefulness, "in providing meaning and direction" of "such conceptualizations of nursing as Orem's, Roy's and Roy's to name only a few." Miss Lewis adds that not any one of the various conceptualizations should be considered *the* magic answer, her point well taken.

Mr. Rajabally doubts the use of a model. I presume he means a conceptual model and I conclude he means a conceptual model for nursing. I suggest that Mr. Rajabally is already using a conceptual model. His teaching must be based on something. He *must* have a way of looking at nursing, he *must* have an idea of what nursing is, if he is teaching it. And his mental image of nursing, however inexplicit and incomplete it may be *is* his conceptualization of nursing.

Mr. Rajabally finds it unfortunate that Redman did not answer her own question. I beg to differ. In reply to "what difference does it make?" she writes "... a conceptual framework or theory alters how one sees reality; nursing needs to experiment with a number of such frameworks in order to gain an expanded and clearer definition of itself as a discipline and a field of practice."

Mr. Rajabally apparently thinks that a conceptual model is "a device that alters perceived reality" and takes issue with Johnson, who, in my opinion, clarifies that point very nicely. I would like to ask Mr. Rajabally how a conceptualization of a reality could possibly *be* that reality.

Mr. Rajabally states that "the adaptation models described by Helson and Roy are thought-provoking." Personally I do not know of any adaptation model by Helson. Helson, a physiological psychologist developed a theory (adaptation-level theory) from which Roy, a nurse drew the assumptions that underly her conceptual model for nursing. And it is quite unnecessary for Mr. Rajabally to pity the students who "often in a state of frustration" must classify their patients' problems as focal, contextual or residual. It is the stimuli to which the patient responds that are classified in those terms.

In his concern for students, Mr. Rajabally also asks "... how can the student concentrate on what she is doing if she must constantly think of the model?" *My* concern for that student includes offering her an explicit way of looking at nursing so that she knows on *what* to concentrate.

Mr. Rajabally wonders at "... our apparent desire to eradicate the influence the medical profession has had upon us ...." No such desire is apparent to me. On the contrary, the conceptual models for nursing that have been developed all indicate the importance of knowledge in the medical sciences.

I am at a loss to understand Mr. Rajabally's observation that "if we are in fact so antagonistic towards all things medical, we shouldn't really be heading for doctoral degrees in nursing." As for his remark about "the first people to be called doctors," allow me to point out to Mr. Rajabally that the first doctoral degree was awarded at Bologna, at the end of the twelfth century, — in civil law!

Mr. Rajabally reports that eleven nursing experts in Europe are studying "this magnificent thing called the nursing process, available only in North America." Those same European experts said of the same nursing process: "It is simply a way of planning nursing care," and "It is really only a more systematic way of looking at what the best nursing care has always consisted of." Their choice of words does not indicate to me any exaggerated admiration of an American invention.

Mr. Rajabally terminates his article with the pious wish that "we assess before we implement." May I suggest that we begin by conceptualizing?

— Evelyn T. Adam, associate professor, Faculté de Nursing, Université de Montréal, Quebec.

Editor's note: Evelyn T. Adam is the author of "A Conceptual Model for Nursing," *The Canadian Nurse,* September, 1975.

Right as rain

Knowing my intense dislike for the pseudointellectual jargon appearing in the professional literature today, a nurse recently presented me with a reprint from *The Canadian Nurse* written by Mohamed H. Rajabally titled "Nursing Education: Another Tower of Babel."

Mr. Rajabally is as right as rain in this article and his criticism of nursing education is absolutely on target. The nursing literature today abounds with bloated verbalization and jargon. Unfortunately such verbalized jargon conceals more than it tells, and often conceals the fact there is nothing to tell.

It is comical and it is sad.

— H.U. Waggener, M.D., Denver, Colorado.

Saved by the babel?

Mohamed H. Rajabally, author of *Nursing Education: Another Tower of Babel?,* has a very refreshing, realistic assessment of the current terminology "fashion" in nursing education.

Nursing and medicine have historically shrouded the professions in mystery, partially through terminology. Now that the consumer is able to interpret medical terminology, does this mean we are losing our mystique and "babel" is a way of correcting this?

— Dorothy J. Irvin, R.N., Springfield, Illinois.

Editor's note: See also page 6

Publications available

Your readers might be interested in learning of three publications of special interest to nurses and now available through the University of Alberta bookstore. They are as follows:

1. *Consumer Rights and Nursing,* J. Storch (Edmonton, Alta. Master's in Nursing Research Trust, University of Alberta, 1977) 235 pages. Price including postage $5.75.
2. *Preventive Mental Health: A Basic Component of Public Health Services.* L. McCullagh (Edmonton, Alta. Master's in Nursing Research Trust, University of Alberta, 1977) 132 pages. Price including postage $2.55.
3. *Development and Use of Indicators in Nursing Research.* G. Zilm et al. (Edmonton, Alta. University of Alberta, Faculty of Nursing, 1975). 220 pages. Price including postage $2.00.

The *Consumer Rights* text is an unusually thorough analysis of the trends, issues and problems. McCullagh's *Mental Health* text is valuable in three major respects: the focus is upon primary prevention, the context is public health, and practical aspects regarding the provision of mental health service delivery in the community are discussed. The *Indicators* text is in its fourth printing due to a heavy international demand.

— Shirley M. Stinson, professor, Faculty of Nursing and Division of Health Services Administration, University of Alberta, Edmonton, Alberta, T6G 2G3.

Sharing rewards and frustrations

I would like to comment on a recent article in *The Canadian Nurse* — "How do you feel about working nights?" (September 1977).

I must say that I feel it was an excellent article because it gave a voice to a wide and varied cross-section of nurses who do work nights. It got to the point, and my reaction to it was very empathetic.

....I feel that these types of "polls" play a very important role for Canadian nurses. I think it would be a good idea to carry on with such questionnaires in various areas of nursing — specialty areas, med-surg nursing, public health and so on.

All of us feel the frustrations and rewards of nursing, no matter where we work ... it would be a good idea to "air" these feelings ... it lets us know how other nurses across the country feel, and gives us an idea of where nursing is heading *now*.

— Maureen Morrice, Winnipeg, Manitoba.

An international role

We read with great interest the August issue of *The Canadian Nurse* which carried articles on international nursing and in particular a report on the recent proceedings of the International Council of Nurses.

This organization of nurses strikes us as one of the most important, in fact, necessary developments in the nursing profession . This is particularly true in light of the call and obvious need for change within health care systems throughout the world — including Canada.

The World Health Organization, as noted in your issue, is promoting primary health care systems in the Third World. The financial drain of our own modern health care systems and the exclusion of individuals and communities in their own care has led to a call in some quarters in North America for an expansion of the role of nurses and other health care workers and to the promotion of "self-care".

In all of these needed changes, the role of the professional nurse is paramount, both in his/her role in bringing about the changes and in participating fully in a new role. Irma Sandoval Bonilla points out on page 47 the implications for nurses of this expanded role:

— "training in primary care of community members and nursing auxiliaries,

— coordination and integration in manpower resources for the health sector,

— new concepts of nursing legislation."

We share responsibility with our nursing colleagues around the world for the evolution of better and more appropriate health care systems.

We would welcome more such articles and feel that by discussing and presenting international health concerns and issues Canadian nurses will become aware of their broader responsibility and role.

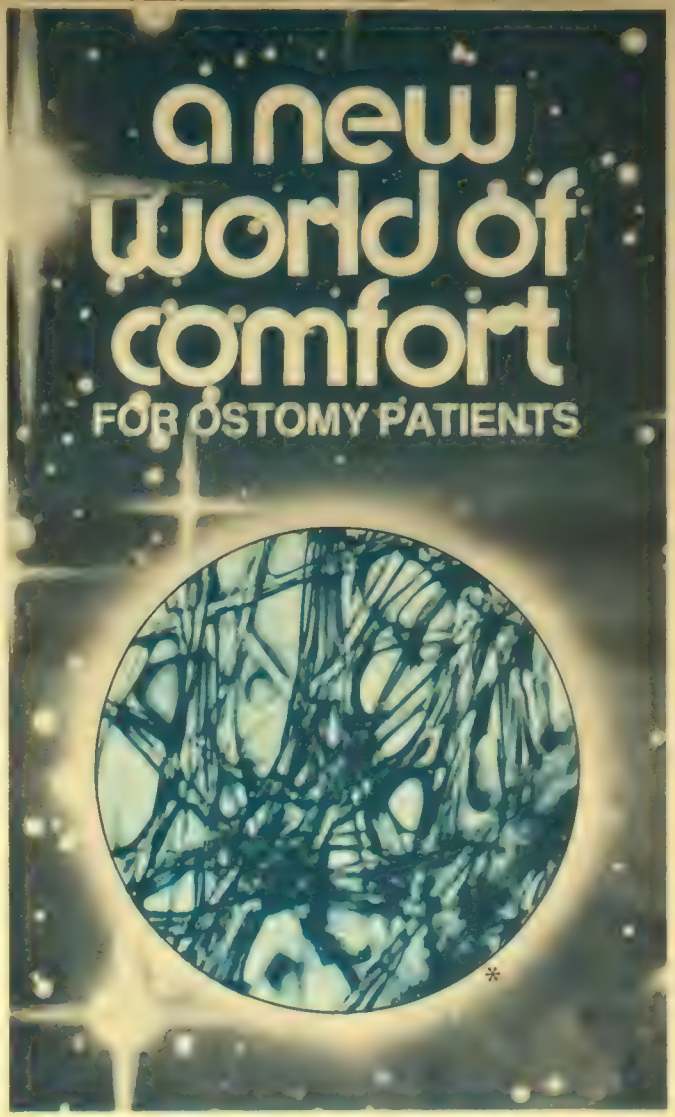
— Janet MacLachlan, Margaret Graham, CUSO Health Programme, Ottawa.

Did you know ...

A highly succesful workshop in cardio-pulmonary resuscitation was held in Sioux Lookout, Ontario on Oct. 4-5, 1977. Sponsored by the Ontario Ministry of Health Ambulance Services Branch, the program was initiated by the Sioux Lookout Chapter of the Registered Nurses Association of Ontario and is the first of its kind in northwestern Ontario.

Canada may have a second research center devoted to the study of ethics for all professions, including law, medicine, science and business, by July of next year. The announcement that plans for such a center were under active consideration was made during a Colloquium on Bioethics held at the University of Western Ontario in London in October and came in the form of a joint statement issued by UWO president, Dr. George Connell, and W. Lockwood Miller, president of Westminster College.

Canada's first center for enthical studies, the Center for Bioethics, Clinical Research Institute in Montreal, was founded in 1976.



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FRANKLY SPEAKING

From a letter to Mohamed Rajabally .. "every day we at CNJ receive another response to your "Tower of Babel" article. So many articles appear in print with never a whisper of a reply to their content. Now, nurses, and especially nurse educators, are talking to other nurses across the country. It seems you have touched a nerve .."

Dear Mr. Rajabally

Theory in Practice

Gail A. Prowse

My comments are a response to the September article "Nursing Education: Another Tower of Babel" by Mohamed H. Rajabally. I felt obligated to provide a perspective on nursing education that differs considerably from that of Mr. Rajabally.

To begin, I would like to comment on Mr. Rajabally's initial suggestion that the nursing process is a deceptive attempt to make problem solving unique to nursing; that, furthermore, it is a waste of time teaching students something that any rational creature already knows.

Rational creatures may solve problems daily. But if they are not nurses, they are not solving nursing problems. Hopefully, it is the application of rational decision-making to the nursing situation that nursing students are learning. The fact that we have been busy "consuming time and money" to integrate the nursing process into our curricula and texts (not to omit nursing practice as does Mr. Rajabally) only attests to our historical reluctance to clearly state what problems and decisions nurses do make.

Mr. Rajabally continues that nurse educators ought to be accountable to consumers who "cry out for better nursing care, not more elaborate theories." I agree that in any service enterprise, accountability to the consumer is important. It is my own regrettable experience that patients do *not* demand better care: however, if they *do*, then they shall naturally want to support only the kinds of theories that make for better care (for example, support theories which are used to teach nurses to give care based on knowledge and decision making rather than on tradition and rote performance). To the degree to which Mr. Rajabally is suggesting that better nursing care has nothing to do with theories of nursing practice, he is promoting an anti-professionalism which I have considered no self-respecting nurse will tolerate.

Mr. Rajabally also questions the use of conceptual frameworks, pictorial or graphic ways of illustrating the design of an educational program. Apparently, he discards what he states is a common defence for the use of a conceptual framework — that it provides a series of reference points — and he never makes it clear why having a framework is so objectionable.

He refers instead to Lewis's editorial, an editorial stating that conceptual frameworks "sometimes do more to confuse than enlighten." Obviously, such frameworks are not useful, but this is no reason to abandon conceptual frameworks altogether. It merely calls for developing or finding frameworks that do the job better.

Next, he wonders why we use models to help nursing students understand their role. It is a big transition for general practitioners of nursing to grow from nurses who perform (and thus see themselves) as doers of tasks *to* patients *for* doctors, to nurses who practice according to an internalized understanding of who they are. The latter recognize that they are the health team members whose chief business is to knowledgeably anticipate, recognize and respond to the general effects of the diagnosis, the treatment and the experience on the patient's optimal (normal) functioning.

Any kind of model (traditional or new) is understood when we understand the concepts that underlie it. Newer models of what a nurse is require the student to understand such concepts as nursing process, adaptation, the subjective nature of health and illness, physical and psychosocial development and general pathological processes, to name only a few.

The fact that investigators like Margretta Styles discover that we are using many variations of a few major patterns or concepts is *not* evidence that we should not use concepts at all, as Mr. Rajabally seems to claim. It merely indicates that with more comparison of models we will evolve a more common language with which to describe the nursing perspective on patient care and the nurses' place in the health team.

Mr. Rajabally misses that point in his notion that models or theories are invented for their own sake or to distract students from what they are doing. Models evolve from and are tools used to explain or describe the real world of nursing experience.

Hopefully, his closing remark about our desire to eradicate the influence of the medical profession is a generalization which has offended most of my nursing colleagues. Antagonism towards *any* team member based on their professional category is indeed irrational behavior. Should Mr. Rajabally meet with such attitudes in nurses, I would hope he would see his responsibility in helping them examine the basis for their anarchistic desires.

Gail A. Prowse *(R.N., Nightingale School of Nursing, Toronto, Ontario; B.N., Dalhousie University, Halifax, N.S.) has had six years teaching experience in Ontario diploma programs. She is presently an M.Ed. student at Queen's University, Kingston, Ontario.*

The unreal world of nursing theory

José de Cangas

I have read with great interest and glee Mr. Mohamed H. Rajabally's article, "Nursing Education: Another Tower of Babel?", which appeared in the September issue of *The Canadian Nurse.*

As someone who has for a long and unfruitful time, pointed out the danger of pursuing a "model," which is preceded by the word "nursing," for the purpose of jumping onto the bandwagon for professional status, I find Mr. Rajabally's comments realistic in this most unreal world of nursing theory.

I also wonder if this futile search for a "scientific model of nursing practice" through borrowing and relabeling concepts long ago discarded by other disciplines, is not akin to the search for professionalism that the chiropractors, and before them, the neuropaths indulged in some years ago. It is clear to me that our colleagues have read the sociological theory concerning professionalism, and without much thought, are desperately trying to apply it, regardless of the situation, to nursing. What is probably more dangerous are the statements of nursing practitioners regarding clinical expertise.

As a member of the "old" school, I *still* believe that Mr. Rajabally put his money where his mouth is, — our profession is at the side of the patient (at least largely), and not by discrediting nursing practice and appealing for the application of obscure and non-testable models.

Of course, if one builds a theory around false premises without testable hypotheses and lacking the power of inferential analysis, he or she may be accused of charlatanism. But this seems to be of no concern to some in our discipline.

I agree with Mr. Rajabally's comments about the medical profession. After all, it seems that Nursing and Medicine have the same relationship as the partners of a neurotic marriage, where one partner complains of being mistreated, beaten, abused, and the other partner complains that he beats because his partner demands it. Neither partner can bear to separate from this neurotic pattern.

In any case, regardless of what our "nursing leaders" are trying to pull in front of a naive and easily impressed discipline, it will be clinical proficiency that pulls us through when all the blocks and arrows of the "modelist" become unglued and hit them in their coccyx.

I enjoyed the article, and it is refreshing to find that someone still looks ahead without fear and pretensions.

José de Cangas *(R.N., R.P.N., B.N.) is presently Director of Nursing Education, Brandon Mental Health Centre, Department of Health and Social Development, Brandon, Manitoba.*

In defense of the nursing process

Isabelle Seburn

Nursing has been evolving through many centuries. It has manifested itself in the mothering activities of women, as the handmaiden of the physician, as healer on the battlefields of the world's wars, and more recently, as the instrument of complex institutions. Nursing has been involved in a struggle against servitude, military domination and exploitation by employing institutions. As Ashley states "Our very history can be described as a power struggle: the struggle to obtain a proper education, ... to throw off the burden of oppression ... for the freedom to practice without ... extraneous restraints and restrictions."[1]

With freedom however comes responsibility ... and responsibility for nursing lies in gearing most of its energies toward improving nursing practice ... a responsibility that will only be realized when nursing defines, delineates and articulates its purpose and function scientifically. Any science demands a scientific approach, and nursing has just begun to make such demands of itself. Not as a fleeting fancy or "in" trend but rather as part of its natural evolution into a science and a profession.

What name shall be given to nursing's scientific method?

- the nursing process?
- problem-oriented nursing?
- nursing diagnosis?

It doesn't matter.

How many steps shall there be in the process?

- four? ... identification of the problem, data gathering, planning and evaluation?
- three broader categories or steps? ... assessment, intervention and evaluation?

Again, it doesn't matter.

What matters is that the nurse approach nursing as "a critical thinker who begins each problem solving task with "why" and not "how" ... as one who does not observe passively but rather explores. Such a nurse is more than a fact gatherer but is a seeker of the optimum care for his or her patient at this time in view of his or her knowledge of the patient yesterday and today, and in view of his or her anticipations of the patient's responses tomorrow."[2]

Of course the elements of the nursing process are not revolutionary or even totally new, but putting all of the elements together in a logical way is new. The complexity of care today makes it essential to determine where nursing intervention is needed, why it is needed, and how it should be accomplished. Nurses have always had to determine what nursing actions they would perform, but their decisions have rested to a great extent on intuition, experience, habit, knowledge and sometimes, on ignorance. Now nurses have at their disposal a means by which they can make rational and orderly decisions, with striking and beneficial results for their patients and for nursing itself.[3]

For too long nursing has been the passive, obedient shadow of medicine, its practitioners frustrated and dissatisfied. This predicament could not be explained away as a deficiency in behavioral traits or attitudes of nurses. Nor could it be explained as a need to enhance the quality of nursing education.

Both these problems have been dealt with and yet the predicament remains. In education and in practice, nursing has not been able to articulate and exercise a distinct function which characterizes and justifies its work as a profession.[4]

Today nursing literature bulges at the seams with statements of nursing function and schemes for its implementation. Any who speak for nursing are speaking about a function that is unique to nursing — the nursing process.

It is paramount that we read the literature carefully in order to organize and assimilate the many parts into a meaningful whole. The message will in the end be clear, for nursing has a definite structure and a unique method of function.

Like any profession struggling to be born, nursing will feel discomfort and confusion. Efforts are already merging into a clearly definable statement of function that will be articulated and exercised in education, theory and practice. I believe this clearly definable statement of function to be the nursing process ... The key to nursing as a unique and viable profession.

Isabelle Seburn *(R.N. Toronto General Hospital School of Nursing, Toronto, Ontario; B.Sc.N. Ed. University of Ottawa, Ottawa, Ontario; M.Sc.Ed. Niagara University, Niagara Falls, New York) is presently on the teaching staff of The Mack Centre of Nursing Education, Niagara College of Applied Arts and Technology, Welland, Ontario.*

Nursing: The total concept

Barbara Boyle
Joan Murthy

The knowledge explosion that has taken place in the Twentieth Century has affected every field of endeavor and nursing is no exception. The question is, how can nurses deal effectively with the amount of information and the rapidity with which it is produced?

The Conceptual Framework

A conceptual framework provides us with a method of organizing an ever increasing body of nursing knowledge, giving us a logical way to view the phenomena with which we are concerned. A conceptual framework abstractly freezes a moment in time, allowing us to view components separately in relationship to each other and as an integral part of the whole. In this way it provides direction in utilizing that knowledge because it helps us realize who we are, what we are and where we are going.

How does a conceptual framework provide this guidance? Simple analogy helps:[1] a pile of brush consisting of roots, leaves and branches can be perceived as meaningless unless we recognize the relationship of the separate components to each other and as part of the whole, unless we recognize a *tree.*

Conceptual frameworks are both personal and professional. Each individual has a personal conceptual framework which reflects his values and beliefs, and is reflected in his conduct. This may be referred to as a personal philosophy of life and is present whether or not the individual is aware of it.

The professional conceptual framework may be a simple statement of philosophy or a more complex model. Models can be in a variety of forms but usually include major concepts such as Man, Society, Health, and Nursing as well as sub-concepts and theoretical formulations that relate to the major concepts, thus providing a series of reference points.

If our personal and professional conceptual frameworks do not coincide, conflict will ensue. For example, if an individual does not personally view man as a unique person with worth and dignity, it would be impossible to portray this belief in his professional practice.

In developing and utilizing any conceptual framework, care must be given to prevent it from becoming more important than the real world. It is intended as a guidance mechanism and must be consistent with reality, rather than forcing reality to be consistent with it.

The Nursing Process

Nursing process is a way of actualizing the conceptual framework. You cannot put the cart before the horse and in the same manner you cannot utilize nursing process without direction. It is true that nursing process is a problem-solving approach, but it has been developed as a tool to deal with both simple and complex problems in nursing practice by defining patient problems, the patient's role, assessment criteria, and the when and how of nursing intervention and evaluation.

In summary

Mr. Rajabally suggests in his article that complications have been created by the conceptual framework and nursing process. We do not believe this is the case and, in fact, believe that the conceptual framework provides the opportunity to visualize nursing as a total concept with three essential components — practice, education and research.

Problems arise when these three components are viewed in isolation from one another rather than in their inter-relatedness and interdependence. We must, as individuals and as professionals, realize the merits of practice, education and research individually and collectively and be able to combine all three components in order to make available to the consumer all that nursing has to offer.

Footnote:

1. Personal communication with Anne Blatz, B.Sc.N., Assistant Director of Nursing, Edmonton General Hospital, Edmonton, Alberta, September 28, 1977.

Barbara Boyle *(M.S.N.) is assistant director of nursing, Standards and Education, at the Edmonton General Hospital, Edmonton, Alberta.* **Joan Murthy** *(R.N.) is a nurse clinician at the Edmonton General Hospital.*

References and bibliographies for these articles are available on request from the CNA Library.

News



Photo courtesy McFadden

Pictured at the ceremony honoring Dorothy Percy are, (left to right) Isabel Black, chairman, National Health Committee, Canadian Red Cross Society; Helen K. Mussallem, executive director, CNA; Dorothy Percy; Gov. Gen. Jules Leger; Janet Chatterson, national coordinator, Health and Community Services, Canadian Red Cross Society.

Canadian nurse receives international recognition

One of this country's most distinguished nurses, Dorothy May Percy, has become the thirteenth Canadian to receive the Florence Nightingale Award. Governor General Jules Leger made the presentation, the highest international award a nurse can receive, at a ceremony at the national headquarters of the Canadian Red Cross Society in Toronto on November 1.

Until her retirement in 1967, she held the post of chief nursing consultant for the federal Department of Health and Welfare, forerunner of the existing position of principal nursing officer, Health and Welfare Canada.

Dorothy Percy began her 42-year career in nursing following graduation from Toronto General Hospital in 1924. She obtained her Public Health Nursing Diploma from the University of Toronto one year later and worked at the Ottawa Civic Hospital before joining the Victorian Order of Nurses. She lectured at the University of Toronto school of nursing until the outbreak of World War II when she joined the Royal Canadian Army Corps. She was discharged with the rank of Captain.

As supervisor of nursing counselors for the newly created Department of National Health and Welfare, she was instrumental in organizing and setting up facilities for the implementation of Canada's social service program.

During her career, she was awarded the Red Cross Medal of Honor, the Jubilee and Coronation Medals, the Canadian Volunteer Medal and the Defence of Britain Medal. She was the first recipient of the honorary degree of Doctor of Nursing from the University of Ottawa and served for many years as a volunteer advisor to the Canadian Red Cross Society and St. John Ambulance, as well as on committees of the Canadian Nurses Association, Canadian Council on Social Development and University of Ottawa school of nursing.

The Florence Nightingale Award is presented every two years to no more than 36 nurses or volunteer aides throughout the world who have distinguished themselves by their great devotion to the wounded and the sick in times of war and peace.

The International Committee of the Red Cross decided to present this award to worthy recipients in 1912, but the first distribution was not made until May 19, 1920, the 100th birthday anniversary of Florence Nightingale.

Cardiovascular nurses converge on Toronto for fifth meeting

Where is nursing headed? Has nursing responded appropriately to scientific and technological progress? Are accountability and responsibility inherent in the nursing role? These were some of the issues addressed by **Dorothy Wylie** keynote speaker at the Fifth Annual Meeting of the Canadian Council of Cardiovascular Nurses.

Approximately 150 nurses from across Canada came to Toronto to attend the two-day October meeting to discuss topics of common interest including: standards of nursing care; current findings in detecting hypertensive patients; and the child with congenital heart disease and his family.

The first day of the meeting focused on standards of nursing practice. As director of the nursing division of the Registered Nurses Association of Ontario and a former cardiovascular nurse, Dorothy Wylie shared her observations of where nursing is headed. She stated that in post-industrial society, needs change very quickly.

"It is the age of specialization but we are still producing the generalist nurse. It is the age of research but we have only a few nurse researchers in Canada."

An anti-intellectual bias is still evident in nursing according to Wylie, who says that there is a great need for higher education if nursing is to produce dynamic leaders.

Inherent in the nursing role is accountability and responsibility, an accountability which can only be measured against established standards of nursing care. At present, each province is at a different stage in establishing standards of care. With the assistance of nurse adviser **Norah O'Leary,** the Health Standards Directorate of Health and Welfare Canada is also establishing standards for nursing. In Wylie's view, if nursing does not set standards for itself, then others will impose them.

The U.S. experience in implementing standards of cardiovascular nursing practice was described by **Grace E. Brown,** clinical nurse specialist at Cornell University Medical Center in New York State and president of the Council on Cardiovascular Nursing of the American Heart Association.

Thérèse Poupart specialist in medical-surgical nursing and part-time professor at Montreal University, discussed the possible effects of standards of cardiovascular nursing in Canada.

Audience discussion at the end of the day made clear that the question of standards is a complex issue, and that one of the first priorities is to establish common definitions of terms.

Day two of the conference dealt with many topics:

- the results of hypertensive screening clinics in Newfoundland;
- a discussion on patient compliance;
- the needs of children and parents;
- a look at activity levels of M.I. patients as perceived by the patient and spouse.

At the close of the two-day meeting, members elected a new executive to the CCCN. They are:
Chairman: **Jean Petrie,** Halifax, N.S.
Vice-Chairman: **Judith Shields,** Vancouver, B.C.
Treasurer: **Glenys Whelan,** St. John's, Nfld.
Recording Secretary:**Thérèse Poupart,** Montreal, P.Q.
Membership Secretary: **Madeleine McNeil,** Halifax, N.S.

Immediately following the CCCN meeting was the annual meeting and scientific sessions of the Canadian Heart Foundation and the Canadian Cardiovascular Society, meetings which CCCN members were invited to attend. Of particular interest was a one-day symposium on cardiac pacing.

The CCCN began in 1973 with some 200 members. With more than 700 members now, the council seeks to promote the quality of health care as it relates to cardiovascular function.



Nurses from all across Canada attending the national seminar on standards included: Seated (left to right) Jean Dalziel, assistant director, professional standards, College of Nurses of Ontario; Norah O'Leary, nurse adviser, Health Standards Directorate, Health and Welfare Canada; Debbie Lee, chairman, special committee on standards, MARN; Deidre Blank, nursing consultant, standards, MARN; Margaret Harvie, vice-chairman, special committee on standards, MARN; Dorothy Wylie, director, nursing service, RNAO. Standing (left to right) Clarrie Case, assistant director of nursing, Grace General Hospital, St. John's, Nfld., ARNN; Alice Furlong, assistant executive secretary, ARNN; Vivian MacDougall, nursing coordinator, NBARN; Jean MacLean, consultant, nursing service, RNANS; Harriett Hayes, chairman, nursing committee, NBARN; Mary Johnson, director of nursing, Camp Hill Hospital, Halifax, N.S., RNANS; Miriam Pill, Canadian Council on Hospital Accreditation, Toronto, Ont.; Marjorie Hewitt, nursing consultant, SRNA; Kitty O'Shaughnessy, project coordinator, SRNA; Barbara Boyle, subcommittee to develop practice standards, AARN; Linda Ross, supervisor, Stanton Yellowknife Hospital, NWTRNA; Myrtle Tregunna, assistant director, nursing services, RNABC; Anita Whittal, general duty nurse, H.H. Williams Memorial Hospital, Hay River, NWTRNA; Betty Sellers, nursing consultant, service, AARN.

ARNN presents brief on nursing homes

In reaction to the Chafe Nursing Home Fire in suburban St. John's, Newfoundland last December, the Association of Registered Nurses of Newfoundland has submitted a brief to the Royal Commission charged with investigating the incident. The brief was presented to Judge Gushue by Ada Simms, chairman of the AARN committee in late September.

The brief attempts to address the serious problems related to the aging population and the kinds of facilities currently available to them. Among other facts known and recognized by professionals, the brief points out that:

- in some cases, staffing in senior citizen homes is "insufficient in numbers and quality to care for these persons"
- "with some obvious exceptions, nursing services are provided by untrained personnel"
- "with limited community services, converted residences have been the only alternate accommodation for most bed-fast patients"
- "the application of sound standards for the operation of Homes for Special Care is the only means whereby adequate care of the individual therein can be assured."

In the section entitled "Staffing and its relationship to standards of care," the brief states that in some institutions for the elderly "there is no preparation for the dying patient. In order to prevent upsetting the aged ill, these patients are moved from wards to the corridor to die. In other institutions, they are left alone in a room without the support of caring skilled persons to provide comfort." The brief cites other examples of neglect. "These situations are, in our view, not only illegal but grossly immoral," it states.

The many recommendations of the brief touch on alternatives to residential homes for senior citizens, on the need for a clearer definition of the role of existing Special Care Homes, on the need for formal administrative education for nursing home administrators and directors of nursing and on the need for an increased number of professional staff to work with the elderly in nursing home settings.

The main recommendation of the submission is "the need for the implementaiton of the Accreditation Program for Extended Care Centres, through the Canadian Council on Hospital Accreditation in all Homes for Special Care in this province."

At present, the Royal Commission is still conducting its hearings.

Yukon federal health services transferred

Two hundred and fifty employees, many of them nurses, are among the people affected by the transfer of federal medical services to the Yukon Territorial Government. Announcement of the transfer, which is scheduled for completion by March 31, 1978, was made in mid-October by Health and Welfare Minister Monique Begin.

Six hospitals, three health stations and nine health centers are affected. All federal employees are being given the opportunity to transfer.

Under the terms of the new agreement the Yukon Territorial Government accepts responsibility for virtually all health care in the Territory including the delivery of health services to status Indians for whom the federal government continues to retain ultimate responsibility.

National Association Directors Meet at CNA House

CNA directors held their last meeting of 1977 in Ottawa on October 20 and 21. Three new directors, elected president of their provincial association since the last meeting of the CNA Board of Directors, were in attendance. They were: Sue Rothwell, RNABC; Irmajean Bajnok, RNAO; Judith Oulton, NBARN. Three new advisers to the directors also attended: Mary Lou Pilling, registrar, NWTRNA; Maureen Powers, executive director, RNAO, and Joan Mills, executive secretary, RNANS.

Directors were brought up-to-date on a variety of nursing concerns by reports from a dozen sources, including committee chairmen, CNA staff, representatives of Health and Welfare Canada and the Canadian Council on Hospital Accreditation. Highlights of these reports follow.

Annual Meeting and Convention Program Committee

Three widely known personalities from the contemporary Canadian scene will headline the program for the 1978 CNA meeting in Toronto next June, according to the chairman of the planning committee, Lorine Besel, member-at-large for nursing practice. They are:

- **David Suzuki**, world-renowned geneticist and controversial host of several CBC radio and television programs, including *Science Magazine*.
- **David J. Roy**, mathematician and philosopher, director of the Centre for Bioethics, Clinical Research Institute, Montreal, which he founded in 1976, and still the only one of its kind in Canada.
- **Laurier Lapierre**, popular television personality, host and interviewer.

More details about the convention program, which is built around the theme of "Ethical Issues in Nursing," will be featured in subsequent issues of The Canadian Nurse.

Standing Committee on Testing Service

Chairman Jean Dalziel indicated in a written report that the Blueprint for the Comprehensive Examination for Nurse Registration/Licensure, scheduled for introduction in the Summer of 1980, had been released to agencies which will be involved in implementing the new examination. The Comprehensive will replace the present CNA Testing Service exams that are divided into five clinical areas — medical, surgical, obstetrics, children's and psychiatric nursing.

The project has been under study by the COTS since 1971. When completed, it will make Canada the first country in the world to use a comprehensive examination for nurse registration on a national basis. It also marks the first time that a national registration examination has been developed in both French and English simultaneously.

Special Committee on Nursing Research

On request, this group carried out an evaluation of the Report of the Ontario Hospital Association Nursing Competency Model Project. This study, involving 45 Ontario hospitals and assessments of more than 800 individual nurses, was highly critical of the "clinical skills, knowledge and confidence" of recent graduates from two-year diploma programs. The report formed the basis of an OHA recommendation that "graduates of two-year nursing programs be required to complete a six-month period of clinical experience before nurse registration is granted."

In their critique, members of the Nursing Research Committee stated: "Based on the incomplete methodology and total lack of presentation of the analysis used, the summary of results is, in the view of the committee, meaningless. For example, there was no rationale stated for the selection of categories and no report of actual statistical findings. This leads the committee to query the reliability of any of the findings presented."

The committee "unanimously and unanimously agreed" that the project had no value for the nursing profession" and expressed concern that the results might be used in any way by nurses.

In response to this concern, CNA directors voted unanimously to make the official reaction of the nursing profession to the OHA Report known to the public, to provincial ministries of health and education and to other agencies.

Principal Nursing Officer

In her first report to CNA directors since assuming office in September, Principal Nursing Officer Josephine Flaherty provided an ongoing review of activities of Health and Welfare Canada. In this, she described some of the implications for nursing of:

- new cost-sharing arrangements between the federal government and the provinces
- the transfer of health services from federal to provincial jurisdiction in the Yukon
- fitness and lifestyle programs
- occupational health programs and the proposed Canadian Centre for Occupational Health and Safety
- the Canada Health Survey which will provide information on the health status and risk factors of Canadians of all ages.

Standards of Nursing Practice Project

Norah O'Leary, nurse adviser, Health Standards Directorate, Health and Welfare Canada, reported to directors on this project which is being carried out in collaboration with CNA and underwritten financially by this branch of the federal government. O'Leary, who began work on the project this Fall, defined the objectives as follows:

- to develop a definition of nursing practice
- to develop standards of nursing practice which are general in nature and applicable to all fields of practice
- to develop standards which are specific to designated specialty areas of practice
- to publish and interpret the approved standards of practice.

Work on the project will be carried out by a 14-member steering committee with national representation and by working parties of experts in the various specialty areas. The first meeting of the national steering committee will be held early in 1978 and working parties will be formed subsequent to that meeting. A target date of two years following the first meeting of the steering committee is visualized by the project director.

Directors approved a recommendation from nurses attending a meeting in Winnipeg on September 29 and 30 (see *The Canadian Nurse*, November, 1977) supporting, in principle, the need for inclusion of an evaluative mechanism/component in the standards of nursing practice project.

Committee on Finance

Directors received a progress report on the implementation of program planning and budgeting by the association in 1978 and endorsed the principle of zero growth for the rest of this year and the year ahead. President-elect Helen Taylor pointed out that stringent efforts to reduce the anticipated deficit were required in order to put the association on a firmer financial footing and prepare it to meet the challenges that nursing will face in the near future. As a result, no new CNA programs will be undertaken without curtailing existing projects.

Canadian Council on Hospital Accreditation

Since April, CNA has had two seats on the board of this national association which, on demand, provides hospitals throughout Canada with survey teams trained to evaluate services provided by these institutions. CNA representatives are Helen Taylor of Montreal, who was appointed chairman of the CCHA board last Spring, and Fernande Harrison of Edmonton. The CCHA is currently engaged in preparing a guide to accreditation of long-term centers of care.

A sabbatical year in international development

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Travel in the field up to	$ 1,000
Research costs up to	$ 2,000
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The Candidate

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2. The professional in the development field who wishes to improve skills or do personal research.

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Research and training areas

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Application

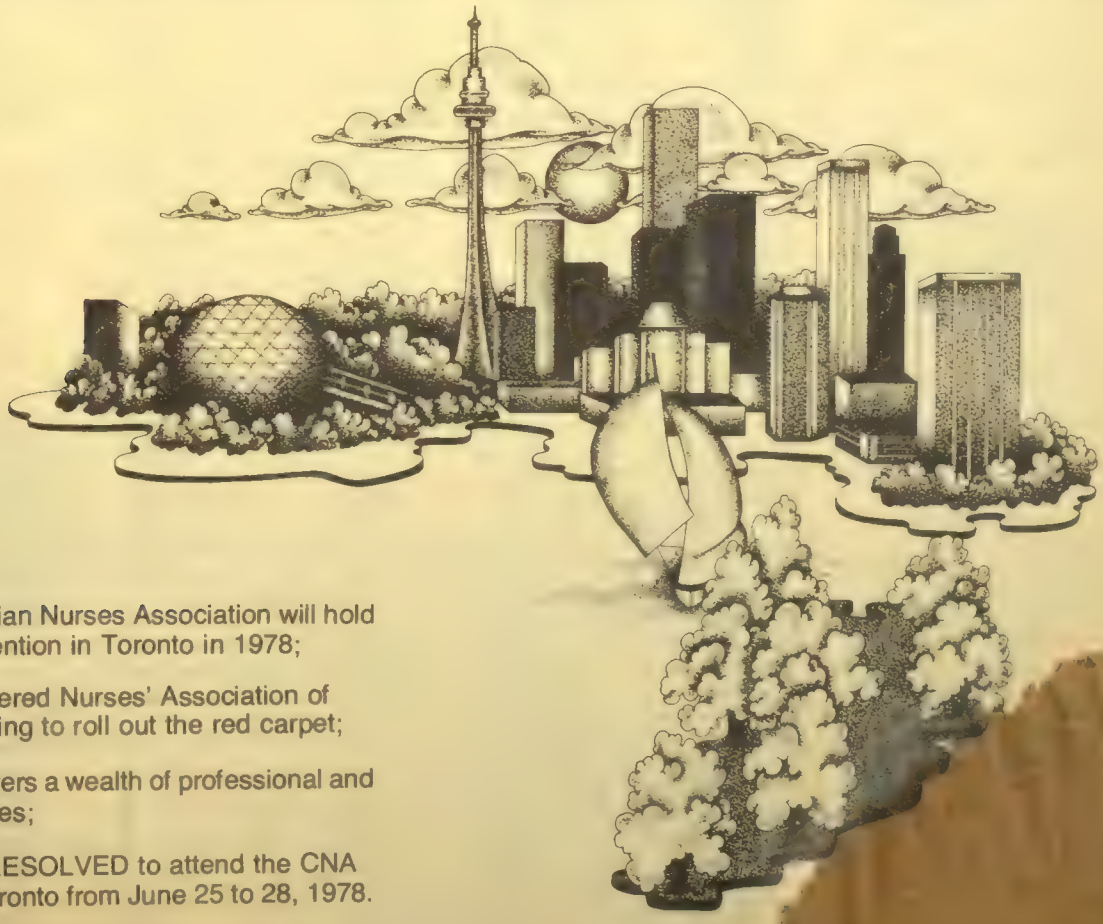
Applications may be obtained from:

Research Associate Award
International Development Research Centre
P.O. Box 8500
Ottawa, Ontario, Canada
K1G 3H9

Forms must be submitted by February 15th, 1978.

Awards will be announced May 15th, 1978.

The International Development Research Centre is a corporation established by an Act of the Canadian Parliament, May 13th, 1970. The Centre also offers Research Associate awards for mid-career professionals from developing countries and for Ph.D. Thesis Research in the field of international development.



WHEREAS the Canadian Nurses Association will hold its biennial convention in Toronto in 1978;

WHEREAS the Registered Nurses' Association of Ontario is preparing to roll out the red carpet;

WHEREAS Toronto offers a wealth of professional and social opportunities;

THEREFORE BE IT RESOLVED to attend the CNA Convention in Toronto from June 25 to 28, 1978.

News

First national survey identifies nurse researchers in Canada

What is the current state of nursing research manpower in Canada? Up until now, no one source has estimated the number of nurses engaged in research in this country But Jan Storch, Clarke Hazlett and Shirley Stinson of the University of Alberta have completed a beginning study to help answer this question by identifying the numbers and types of nurses involved in research in Canada in 1976.

Responses to their survey provided an estimate:

- they found 130 nurses engaged in research;
- 49 to 53 of these nurses were classified as nurse researchers;
- six were full-time nurse researchers;
- over 70% of these nurse researchers were located at universities;
- slightly less than 50% were located in Canada's western provinces.

Who are the nurse researchers? The study focused on the research process in order to measure and define researchers. This process involves generating the research question, designing the study, selecting instruments to collect data, supervising sample selection, content analysis, interpreting the findings, and reporting the results of the study.

For the purpose of the survey, master's and doctoral level qualifications were accepted as suitable preparation for the principal investigator role. Full-time and part-time researchers were included in the study. Respondents engaged in thesis or dissertation research were not included because the purpose of the study was to determine the approximate number of nurses engaged in research as an *occupation*. Research content areas were not restricted.

Letters and questionnaires were sent to 192 teaching hospitals, universities, provincial and city health departments, hospital and nurses associations, and other selected institutions. The authors of the study recognized that their selection of institutions meant that some researchers would be missed. Response to the questionnaires (86.5%) was exceptionally good. Of 168 questionnaires returned, 130 respondents met the requirements of the survey.

Over half of the respondents devoted less than 40% of their time to research, while almost a fifth spent more than 80% of their time engaged in research. Exactly 50% of all respondents held master's degrees; nine per cent held doctoral degrees.

The location of respondents by type of organization showed a not unexpected concentration at universities (47.7%). It was encouraging to find however that 31% of respondents engaged in research were employed in teaching hospitals and 12% in health departments. The majority of respondents were engaged in nursing practice or health services research.

What was the source of funding for research projects? Thirty-seven percent of nurses reported no outside funding, 37% had complete outside funding, and the remainder reported some outside funding. The number of full-time respondents funded from outside the employing organization was cause for both encouragement and concern: outside funding may serve as an indication that the research was worthy of support; at the same time, the research commitment of health related organizations can be questioned. While nurses in hospitals and nurses' associations drew over 65% of their funds for research from within the organization, nurses in universities drew over 85% of their funds from sources outside the organization.

What roles do nurses play in research? The authors of the study assigned a research role to each responding nurse. Nurses who were responsible for generating the research question and providing supervision for the study and who possessed at least a master's degree, were categorized as *principal investigators*. If the nurse was responsible for at least three research activities including supervision of data collection, content analysis, interpreting the findings or reporting the results of the survey, that nurse was assigned the role of *research director/associate*. A *research assistant* was defined as a person totally or substantially involved in no more than three research activities, not including generation of the research question, designing the study, supervising sample selection, or interpreting or reporting the findings.

Sixty to 66 nurses were classified as principal investigators. This range encompasses those who stated their role as principal investigator (66) and those who were assigned that role on the basis of their answers to the questionnaire (60). Using the same method, the surveyors identified 19 to 24 research directors and 19 to 20 research assistants and five "other" (often consultant to one phase of a study).

Forty-nine to 53 nurse researchers identifying themselves as principal investigators held either a master's or doctoral degree. This group included six of the 19 full-time nurse researchers, four located in Alberta, one in Ontario and one in Quebec. Of the six, four were located in universities, and two in health departments.

Of the 47 nurses for whom research was not a full-time endeavor (who stated their role as principal investigator and who held at least a master's degree) 43% were located in the western provinces, 34% in Ontario, 17% in Quebec and 6% in the Atlantic provinces. Seventy percent of these nurse researchers were located in universities, and approximately 20% in teaching hospitals.

A full copy of the report "Canadian Survey for Nurse Researchers" is available on Interlibrary Loan from the C.N.A. Library.

N.B. infection control nurses organize

Infection control nurses in the province of New Brunswick will soon have their own organization reflecting the objectives of their particular area of practice.

Nine nurses working in the field of infection control met this Fall to appoint a president, Helen Parchello, of Saint John, N.B., and to study proposed by-laws. Others on the executive are Denise Boulay of Bathurst and Joline Voye of Woodstock.

The group, which is presently recruiting new members, hopes to become a specialty group of the New Brunswick Association of Registered Nurses and a chapter of the Canadian Hospital Infection Control Association.

The organization's main objective is to encourage the development and standardization of effective and rational infection control programs in provincial health care agencies.

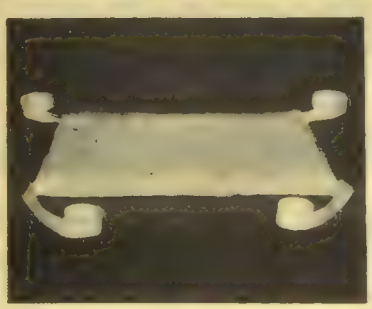
Their second objective is to initiate and develop effective communication among Infection Control Practitioners in order to share acquired knowledge and exchange practical experience.

The Infection Control Group hopes to convince hospitals that infection control is an important part of the hospital health team.

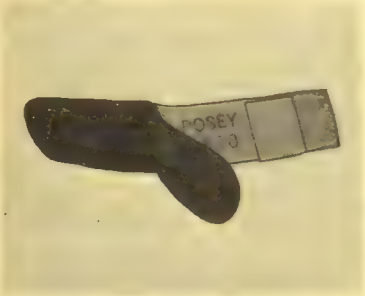
N.S. directors form special interest group

Nova Scotia directors of nursing service from 32 hospitals in the province have formed a special interest group under the umbrella of the Registered Nurses Association of Nova Scotia. At a meeting organized by the RNANS in October, directors agreed on the need to form a united front. Their consensus was that the views of directors should be considered when important decisions about health care are being made. One director commented: "August bodies are developing policies which affect hospital care and nursing and which must be implemented by nursing departments, yet nursing service directors are not consulted."

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Names and Faces

Eileen Flanagan former director of nursing at the Montreal Neurological Institute for 27 years, has been awarded the honorary degree Doctor of Laws (LLD) at McGill University's Founder's Day Convocation.

Flanagan is a graduate of the Royal Victoria Hospital School of Nursing, the McGill School for Graduate Nurses and McGill University. Following her retirement from MNI in 1961, she returned to McGill to study law to aid her in drafting legislation dealing with the nursing profession.

She has made active contributions to nursing especially in the areas of labor relations, leadership, administration and research as well as contributing to many other organizations. Co-author of *The History of the Nursing Profession in the Province of Quebec,* Flanagan is a recipient of the Jubilee Medal (1935), the Centennial Medal (1967), the Province of Quebec "Order of Nurses" (1976) and the Distinguished Citizen Award (1971) from the Montreal Citizen Council. Most recently she has researched a book on the history of tuberculosis in Canada, called *The Miracle of the Empty Beds.*

Scholarships totaling $6,000 have been awarded by the New Brunswick Association of Registered Nurses to students enrolled in university nursing programs during the 1977-78 academic year.

A $2,000 scholarship has been awarded to **Micheline Léger** of Moncton to pursue a Master's level program at McGill University.

Other scholarship awards went to nurses engaged in nursing education at the baccalaureate level. They are:
Fernando Fournier Moncton, N.B.; **Nancy Muck,** Blackville, N.B.; **Paula Quinn** of Chatham, N.B.; **Lynda Finlay** of Fredericton, N.B.; **Diane Frazer** of Moncton, N.B.; **Suzanne Ouellette** of Edmunston, N.B.; **Line Lavoie** of Grand Falls, N.B. **Mary Ann Glass** of Hamilton, Ontario; **Geraldine Ball,** Fredericton, N.B.; **Vivian MacLeod** of St. Stephen, N.B.

Two non-nurses have been appointed for a two-year term to the board of directors of the Registered Nurses Association of British Columbia. They are:
Mary Jane Mulligan of Vancouver, who was nominated for the position by the B.C. Minister of Health. She will serve on the RNABC committee on referral and review which investigates complaints of misconduct by nurses. **Barbara Rolls** of Victoria was nominated by the B.C. Branch of the Consumers' Association of Canada. She is CAC's Victoria president and chairs its B.C. health committee.

Dorothy Hibbert (M.A., B.Sc.) has been appointed Acting Dean of the Faculty of Nursing, University of Western Ontario in London effective July 1, 1977 until June 30, 1978 or until the appointment of a new dean. A faculty member since 1963, Hibbert succeeds Josephine Flaherty who has been appointed Principal Nursing Officer in the federal ministry of Health and Welfare.

Vivian Wood, professor in the Faculty of Nursing, The University of Western Ontario has been included in the book, "Women of Action 1876-1976." The centennial book, published by the Local Council of Women in St. Catharines, Ontario, includes 128 biographical sketches of celebrated women from the area.

Wood is a graduate of the Hamilton General Hospital School of Nursing in Hamilton, Ontario, later attending the University of Toronto and the University of Western Ontario to receive her B.Sc.N. and Boston University for her Master's degree in education. She has taught and researched such topics as student personnel services in nursing education and evaluation in nursing education. Her numerous articles have appeared in many nursing journals. She was an elected member of the Council of the College of Nurses for four years. At present, she is active in the university community.



Judy Lathrop (R.N., University School of Nursing, Edmonton; B.Sc., Nursing, teaching and administration, University of Alberta) has been appointed chairman of the nursing department, Mount Royal College, Calgary, Alberta. She has been employed as a general duty nurse and nursing instructor at hospitals in Alberta and British Columbia and has been a member of the faculty of Mount Royal College since 1973. Currently, Lathrop is completing a Master's degree in educational administration at the University of Calgary.

Therese Schnurr (M.N., University of Washington) director of nursing services for the RNABC has been appointed director of nursing at the Royal Columbian Hospital, New Westminster, B.C. She is a former director of nursing services at St. Paul's Hospital in Vancouver.

Betty Oka (B.Sc.N., University of Washington, M.N., Montana State University) has been appointed director of nursing of the Shaver Hospital for Chest Diseases in St. Catharines, Ontario. Oka was formerly a clinical specialist in cardiovascular nursing in Chatham, Ont., a faculty member of the McMaster University School of Nursing, Hamilton, and most recently a consultant-supervisor with the Niagara Regional Health Unit, Thorold, Ontario.

Among the 18 nurses honored at the 1977 St. John Ambulance Investiture were **Margaret M. Hunter** formerly chief nursing officer for St. John Ambulance in Canada and now national nursing consultant for that organization and **Alice Girard,** past dean of the Faculty of Nursing, University of Montreal, and former ICN and CNA president. Both were invested in the Grade of Commander at the October ceremony held in Ottawa.

Other nurses honored at the Investiture were:
Grade of Dame of Grace: **Irene R. McPhail,** Ottawa; **Lillian Bibby,** Alberta.
Grade of Commander: **Rita Choquet,** Quebec; **Janice B. Morgan,** P.E.I.
Grade of Officer: **Major Nicole M. Du Mouchel,** executive director of the Order of Nurses of Quebec; **Jean Nelson,** N.S.
Grade of Serving Sister: **Doria Vermette,** Quebec; **Tristam T. Coffin,** N.S.; **Michael Hewitt,** N.W.T.; **Thelma J. May,** Ontario; **Mabel W. Linquist,** Ontario; **Mary Lynch,** Ontario; **Margaret Cameron,** Ontario; **Joyce Hastings-Trew,** Ontario; **Margaret A. Fulkerth,** Alberta; **Jean E. Lewis,** Nfld.

Mae Wright, a graduate of the St. Boniface Hospital, Winnipeg, Class of 1930, was honored recently when she was presented with an honorary membership in the Northwest Territories Registered Nursing Association by the Hay River Chapter.

A resident of Hay River, N.W.T., Mae has been involved in the health care of that community since 1949. She contributed to the early nursing needs of the Hay River community and was instrumental in the development of medical services. Among other programs, she started the first Hay River Christmas Seal T.B. campaign, the first immunization program and was directly involved in the planning and building of the first nursing station there.

Calendar

January, 1978

Health Educators Mini Health Care Conference sponsored by the Association of Canadian Community Colleges. Topic: Why Clinical Practice? with keynote speaker, Dr. J. Flaherty, Principal Nursing Officer. To be held at CEGEP Ahuntsic in Montreal on Jan. 16-18, 1978. Pre-registration on Jan. 15 . Fee: $60 for members, $75 for non-members. Contact: *Sr. Thérèse Gauthier, Chairman, Health Sciences, CEGEP Ahuntsic, 9155 St. Hubert Street, Montreal, Quebec, H2M 1Y8.*

Diabetes in Review: Clinical Conference 1978. To be held in New York City, Jan. 25-28, 1978. Contact: *Harry Hansen, American Diabetes Association, 600 Fifth Ave., New York, N.Y. 10020.*

Overview of Paediatric Rehabilitation Course: A Multidisciplinary Approach to Management. To be held in Toronto on Jan. 23-27, 1978. Fee: $75. Contact: *Norma Geddes, R.N., The Education Department, Ontario Crippled Children's Centre, 350 Rumsey Rd., Toronto, Ontario. M4G 1R8.*

Nursing Care of the Sick Newborn, a five-day conference to be held the week of January 30, 1978 at the Hospital for Sick Children, Toronto. Fee: $80. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G IX8.*

February

Toronto Area Interest Group of the Orthopedic Nurses Association Two-Day Meeting to be held at the Hotel Toronto, in Toronto, Ontario on Feb. 9-10, 1978. Contact: *Marion Marshall, Chairman, Publicity Committee, 35 Front Street, Apt. 310, Mississauga, Ont., L5H 2C6.*

March

Sensitivity — An Integral Part of Pediatric Nursing. A one-day conference to be held on Feb. 22 and on March 1, 1978. Fee: $20. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G IX8.*

Current Practices in Breast Feeding and Maternal Infant Bonding to be presented in Winnipeg on March 17, 1978. Fee $10. Contact: *Norma Buchan, Women's Centre, Health Sciences Centre, 700 William Ave., Winnipeg, Man., R3E 0Z3.*

April

Patient Teaching Programs. A one-day conference to be held at The Hospital for Sick Children, Toronto on April 19 and on April 26, 1978. Fee: $20. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G 1X8.*

British Columbia Operating Room Nurses Group's Sixth Biennial Institute to be held April 13-15, 1978 at the Hyatt Regency Hotel, Vancouver, B.C. Contact: *Mary E. Raikes, 106-14412 W. 14th Ave., Vancouver, B.C. V6H 1R3.*

May

Current Trends in Pediatric Feeding Techniques. A one-day conference to be held at The Hospital for Sick Children, Toronto, on May 31, and on June 7, 1978. Fee: $20. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G IX8.*

Nursing Care of the Sick Newborn, a five-day conference to be held the week of May 1, 1978 at the Hospital for Sick Children, Toronto. Contact: *The Coordinator of Nursing Education, Hospital for Sick Children, 555 University Ave., Toronto, Ont., M5G 1X8.*

Autism: Research and Practice. A research symposium and conference to be held at the University of British Columbia in Vancouver on May 24-26, 1978. Contact: *Lois Myerhoff, P.A.A.C. Office, 4125 — West 8th Ave., Vancouver, B.C. V6R 2X3.*

Pediatric Nursing Conference for nurses wishing to increase their knowledge of common pediatric problems and nursing approaches. To be held at the Hospital for Sick Children, Toronto on May 24-26, 1978. Fee: $50. Contact: *The Coordinator of Nursing Education, The Hospital for Sick Children, 555 University Avenue, Toronto, Ont., M5G IX8.*

International Congress of the World Federation of Public Health Associations and the 69th Conference of the Canadian Public Health Association to be held on May 23-26, 1978 at the Hotel Nova Scotian, in Halifax. N.S. Theme: Primary Health Care — A Global Perspective. Contact: *Canadian Public Health Association, 1335 Carling Ave., Suite 210, Ottawa, Ontario, KIZ 8N8.*

Call for Abstracts for the 2nd International Congress of World Federation of Public Health Association and the 69th Annual Conference of the Canadian Public Health Association to be held in Halifax, N.S. on May 23-26, 1978. Theme: "Primary Health Care — a global perspective." Papers relating to primary health care as front-line care in both urban and rural settings are sought in the following categories:
1. Health as an integral part of human development
2. Primary health care as a part of community development activities
3. Primary health care as part of a general health care system.
Papers must be in English, French, or Spanish. Send abstracts before Dec. 31 to: *Dr. Lloyd Hirtle, Chairman, Scientific Program Committee, Room 439, 1557 Hollis St., Halifax, N.S. B3J 1V6.*

September

18th International Congress of Midwives to be held Sept. 3-8, 1978 in Jerusalem, Israel. Contact: *Iris E Campbell, Secretary, Western Nurse Midwives Association, 4007 - 108 Street, No. 35, Edmonton, Alberta, T6J 2L5.*



FOUR SCORE AND TEN



This is the last in our series of excerpts from the unpublished memoirs of Maude Wilkinson. Here we share with Maude her years in the rough 'bush' country of Northern Ontario as she supervises the formation of Outpost Hospitals, her years as Lady Superintendent of a tubercular sanitorium, the fulfillment and ruin of her dream to own and operate a nursing home and then, late in her 79th year, Maude's retirement from nursing. As a Canadian nurse for 47 years Maude Wilkinson's story is a reflection of our own career history. Maude is now 96 years old and living in Sunnybrook Medical Centre's Extended Care Facility, Toronto.

"If I should live to be the last leaf on the tree in the spring,
Let them smile, as I do now, at the old forsaken bough where I cling."



Visiting a northern outpost



Family reunion 1919

Maude Wilkinson

I went to work at the Department of Soldiers Civil Re-establishment (DSCR) soon after I returned to Toronto at the end of the War.

The events in Europe had left so very many scars everywhere. I wanted to try to help veterans and their families adjust to their new world both economically and psychologically.

I found a great many confused and bewildered families during my investigations. The war was over now and the husband had returned home. With his return, his wife's separation allowance had stopped. If the veteran had a pensionable disability, the amount the family received depended on the degree of his disability. In a great many cases the injury was slight and the pension was small.

Then again very often the disability was not pensionable, but still sufficient enough to keep the veteran from finding employment. In these cases the husband had to stay at home and care for the children, his wife had to go out and work.

There were also the young veterans, those who had enlisted while still in their teens before having had a chance to establish themselves in a job. Those men were left loafing around, unemployed. Recognizing the situation the Canadian government organized Training Centres, paying trainees minimum wage. Some took advantage of this offer, others said such training only prepared them for dead-end jobs.

I was faced with many problems. How could I advise these men?

Miss Graham, my supervisor, resigned from the DSCR in the fall of my first year there. I was asked to succeed her. Thinking a short course in Social Services might help me, I asked permission to attend a course at the University of Toronto. Permission was granted as long as I could supervise the office at the same time.

Obviously I had to establish a routine which would include the office work and my studies. Between meeting with and discussing the investigators reports and attending lectures, I had little leisure time that year. I received my diploma from the Chancellor of the University on May 13, 1921.

The office work increased and it became necessary for us to employ more staff. I asked the officer who was interviewing applicants to be careful not to hire anyone who had not been in the army. The successful applicant must be able to look at things from a veteran's point of view.

We hired two knowledgeable young men who were ex-officers, and several graduate nurses, ex-nursing sisters. Included in the group of nurses was a full time graduate of the Social Service Course, Miss Edith Rogers. I really appreciated having Miss Rogers on my staff and grew to depend upon her recommendations.

I stayed with the DSCR for four years and I really enjoyed my work. But I could not avoid the fact that I was still very occupied with returned veterans. I had not, professionally speaking, successfully re-entered civilian life.

In 1923, Miss Holland, the Director of the Red Cross Outpost Hospital Service, Ontario Division called on me. She was resigning from her position and she wanted me to take her place. Needless to say I was very flattered; I accepted the position.

Civilian Life

The Outpost Hospital Service was concerned with the need for hospital accommodation and nursing service in the isolated rural districts of Ontario. It was one of the largest departments in the Ontario division.

My field work was to be directed by a representative committee under the chairmanship of Mrs. A. Plumptre.

Miss Holland took it upon herself to introduce me to the nurses who were directing other departments. I sensed a happy cooperative spirit among [illegible] still the task I was un[illegible]

considerable and I was worried. Would I be able to cope with the work?

After a few days in the office, I prepared to leave to visit the Red Cross's first outpost hospital. It had been established in 1922 at Wilberforce in Haliburton County.

I boarded a Grand Trunk Railway train at Union Station early one morning. I was the only passenger on the train.

The conductor collected my ticket, noted the destination and then sat down to talk with me. I told him that I had been a nurse in the war. He was an ex-service man himself and knew I had experienced many ordeals and had been exposed to great danger.

I was introduced to each passenger as they arrived and the conductor insisted upon relating my life history to them. Each time a new tale was added until even I began to wonder who he was talking about. I didn't want to discredit him in front of the people he met day after day, but I had to stop him when he told someone that I had received the highest award in the country, "The Honour of Merit Medal."

Of course, no such medal was ever struck.



On our way to Red Lake 1926

Wilberforce

The outpost nurse met me at the Wilberforce station. We walked through the village square together until we arrived at a comfortable looking medium-sized house proudly proclaiming itself "The Wilberforce Red Cross Outpost Hospital."

There was a large room on the right as you entered the house. It ran the length of the building and served as a two-bed ward furnished with hospital beds and two comfortable chairs. Both units were divided by a curtain.

There was one patient in the hospital. When I was introduced to him he clung to my hand and said "Please matron, don't take our nurse away. We can't do without her. Until I was admitted here, she visited me every day at my home five miles out of town." I felt sorry for the nurse, she was a quiet self-effacing woman and this really embarrassed her.

I couldn't help but notice that everyone spoke to her on our way from the station and she called back to nearly all of them by name. She was warm and friendly — I liked her manner so much.

A comfortably furnished room in the front of the house served as the staff sitting room. A well and a kitchen pump provided drinking water for the hospital, a cistern provided rain water for other household needs. A little outhouse in the back completed the sanitary

for a couple of days
some of the homes in
yone welcomed us
onder if I would
nother nurse as
visit with her

I boarded the train in Haliburton, now I would have time to sort out my ideas before I returned to the office. I had absorbed a great deal in those few days. It was an experience that would prove to be very useful when I was faced with opening other nursing stations and outposts.

Home Again

I went back to work realizing I would always be the 'Red Cross Representative' sent to meet those in different places who were asking for assistance. This would necessitate my absence from the office frequently. I decided that I should visit the nursing stations and hospitals the Red Cross operated just as soon as possible. My visit to Wilberforce had shown me just how important it was to find the right person for the right place.

I had always been interested in hospital organization and administration. Hospitals like Roosevelt and Wellesley required large expenditures in modern equipment and furnishings to satisfy affluent patients. My army experience showed me that patients could be cared for with a minimum of expensive equipment and still receive quality care. The success of the hospitals that the Red Cross established would depend more on service than on display. The staff must be selected carefully.

Canoes, Portages and Tents

It would be impossible for me to recount all of my visits to outpost stations but one stands out as being of particular interest.

In April, 1926 the Outpost Committee received a request for nursing service and a small hospital in the Red Lake mining district of Northern Ontario.

My first responsibility was to find two graduate nurses who would be willing to go so far away and live a more or less isolated life in a mining camp. They also had to have the ability to cope with any emergency.

I was fortunate — two graduates of the same training school, two sensible young women, applied. Together we chose a suitable uniform — a plain dress worn with an apron and a Red Cross arm band while they were on duty.

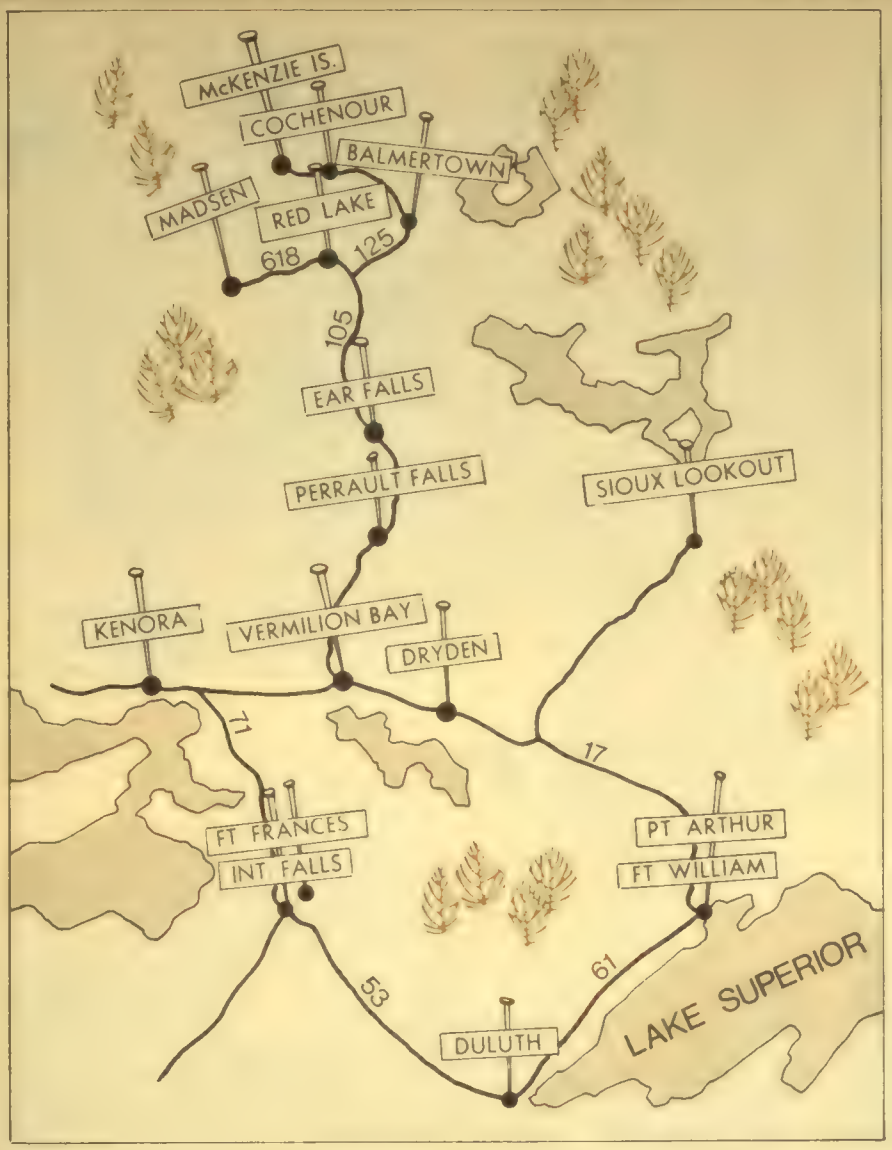
It took me quite a while to buy all of the equipment. I wasn't used to the kind of operation that was proposed for Red Lake.

Three tents were bought — a large one for hospital purposes, a smaller one for the nurses' living quarters, and one for storing supplies. I had to buy folding iron cots, with good comfortable mattresses, pillows, Hudson Bay blankets — everything for household purposes. We had accumulated 7000 pounds of supplies by the time we left.

There was no electricity at Red Lake so I included Coleman lanterns, stoves and a hurricane lamp — my army experience really helped as I tried to visualize and prepare for every possible situation.

We left Toronto via C.P.R. the night of June 25th and arrived in Dryden the following morning. Dr. and Mrs. Dingwall were ready to leave. There was a little man named Papke with them. I never found out where he came from or who hired him, but Papke was indispensable — a strong, wiry little man, willing to do anything. The six of us took the train to Hudson where we spent the first night — or rather part of the night since we left Hudson at about five a.m.

Our supplies, 7000 pounds of them, were loaded into five freight canoes which were





manned by eight Indian guides. We all boarded the pointer boat; it had an outboard motor and towed the canoes.

We reached the Lac Seul Hudson Bay Trading Post in the evening and met the managers. Mr. Aldous was in a smart summer suit — we felt so grubby and bedraggled in comparison. With great pride he showed us his miniature golf course. We were able to take advantage of this opportunity to buy extra food supplies from the store.

The guides warned us that Lac Seul became very rough in the late afternoon so we couldn't stay too long. Leaving the boat at Lac Seul we walked the first portage to upper Ear Falls, another portage to lower Ear Falls and then a longer portage from there to a beautiful spot where the English River joined another river.

It was on that last portage that we met three men returning from Red Lake. One was evidently a gentleman of some means. He asked Dr. Dingwall, what four fashionably dressed white women were doing in this rough mining district? Dr. Dingwall told him we were all graduate nurses going to Red Lake to establish a hospital.

That surprised him — he didn't know what to say.

We were very tired, our feet ached from walking steadily since five a.m. — over thirteen hours. The guides took us to a shallow place where we could wash and bathe our feet. Then they served us cold roast moose sandwiches (which were delicious) and 'piping' hot coffee made over a camp fire. We asked the guides to make our 'cedar bough couches' and settled down for the night. I can picture us even now, lying five in a row, like five bowling pins knocked down in an alley. Dr. Dingwall couldn't help but laugh, what would the gentleman from Toronto have to say about the four 'grounded' fashionably dressed ladies

We were roused at four a.m. to cross Pakwash Lake before it became too rough. There were three more portages to cross that day.

The pointer boat was waiting for us at Pakwash Lake. We got on board very grateful to sit down. We arrived at Red Lake about four p.m. June 30th. It had taken us three nights and four days to reach Red Lake from Hudson.

Two log cabins and some tents were visible from the lake. Two men came down from the cabins and introduced themselves; Dr. Fitzgerald, the mine doctor, and Mr. James the assistant manager of the mine. They lead us through the brush and when we arrived at the cabins Mr. James took us to the cabin he stayed in. There we found a basin and pitcher of water and so we could tidy ourselves. We were a sorry looking gro[illegible] dresses' had been live[illegible] slept in for three [illegible]

Dr. Ding[illegible] go to the other [illegible] had both gra[illegible]

Medicine at Queen's University. When Dr. Dingwall reappeared, he was relaxed and laughing heartily with Dr. Fitzgerald apparently recalling some prankish university escapade. Dr. Dingwall seemed quite oblivious to the fact that the immaculate suit he had left Dryden in was spotty and wrinkled.

Sherry was offered to the women, something stronger for the men, and our conversation soon became very animated — yesterday's thirteen-hour pilgrimage was forgotten. The next day, July 1st, was a holiday, but still Mr. James detailed eight of the mine employees to clear a lot, 100 x 250 feet for our tents. The men seemed pleased to be helping, they seemed comforted to know they could be cared for if they were ill. By noon, the flooring was nailed to the logs, the cracks in the flooring plastered over and the large tent securely fastened down — the hospital tent was up.

Nine other men arrived in the afternoon and following the same procedure they finished the nurses' tent. We were able to move in that night. The storage tent was ready before noon the next day.

In the meantime, Dr. Dingwall found there was no trail to the post office which was located some distance from the camp (the mail arrived by air every week). With an axe and a saw he started to clear a path that the nurses could navigate. It was a slow process, the brush was thick.

In the evening Dr. Dingwall told us that the history of Red Lake dated back to the seventeenth century. He said as he cleared the path he thought of those early settlers who travelled by dog team on land and by canoe on water. What great suffering they had to endure.

After several days, Dr. Dingwall noticed a sign nailed to a tree on the trail near our camp — "Dingwall Avenue" — his labor had not gone unrewarded.

The next few days were very busy — as Papke unpacked the supplies and took them to the tents, we put everything in its place. Mr. James arranged for the mine carpenter to build some shelves and cupboard space for us.

Almost too soon it was time to leave. Mr. James asked Captain Oake, pilot of the 'Lark' to fly us out. Dr. and Mrs. Dingwall climbed into the plane sitting behind the pilot. They had to wait for me. As a matter of fact, I had to be lifted up. My heart was in my mouth and I was too afraid to let go and wave to the nurses I'd left on the ground.

I had been living out of a suitcase for thirteen years and I was beginning to think seriously of leaving the Red Cross. The life of a traveling salesman was no job for an old lady of 52.

I was offered the position of Lady Superintendent of Weston Sanitorium caring for patients suffering from tuberculosis. I think it was the opportunity to be a Lady, the opportunity to settle down and stop rushing all around the province that made me decide to accept the position.

I told Dr. Dobbie, the superintendent, that I had no experience in the care of tuberculosis and he promised to help.

I discussed the position with Miss Russel, the Director of the School of Nursing at the University of Toronto. She thought it might be a good idea for me to observe the work of some American Public Health departments. I was granted a scholarship and I left to travel to southern Tennessee.

The scholarship allowed me to travel as I wished. To the amazement of my friends, I decided to go by bus and return by rail. You see I really do enjoy traveling.

The district I went to was isolated with a predominantly colored population. The nurses were very friendly and I went on all their rounds with them. Tuberculosis ran rampant in the community and because of the people's attitudes to disease, the nurses seemed to be fighting a losing battle. I didn't envy them in their work.

When I told them of the position I was accepting, they agreed with me — my situation would be very different.

Weston Sanitorium

When I returned to Toronto, I moved into the nurses' residence at the sanitorium. I had





Red Lake 1926







never had such an elaborate suite before. My living room was large enough to take all my furniture. There were two bedrooms with a connecting bathroom and at the end of the living room there was a completely equipped kitchenette.

It was an apartment designed for a Lady. There was only one drawback — the lady had no time to enjoy it.

One of my responsibilities was the supervision of the nurses. I was lucky because my staff was made up of nurses I could rely on to supervise the wards and to provide quality nursing care.

I was responsible for the feeding of 600 patients and 200 employees. Each morning the Chef came to my office to discuss the daily menu and give me the list of supplies he needed. We both thought that the hospital food costs were too high and meat seemed to be our greatest problem. The nurses told me the patients complained as soon as they received their trays. "Stew again! — Stew again!" — or mince patties or meat loaf.

I really wanted to work at correcting this situation, so I started by asking the Chef why he always ordered carcasses. There was so much fat and muscle to be discarded and the result was that only one or two meat portions could be roasted. I decided to experiment and buy roasts, rolls for boiling, bones for soup and some lean meat that could be stewed.

The Chef was frightened. He was afraid the cost would be high and the doctor (whom he thought wonderful) would be put out. Nevertheless, I ordered cuts (roasts and rolled boiling beef) instead of carcasses for a month.

When we received the bills at the end of the month, we found the cost was no greater. Better still the patients were satisfied and there were no complaints. I noticed the nurses were enjoying the change too. The Chef was smiling and best of all, Dr. Dobbie approved.

I think I would have stayed at Weston longer if Dr. Dobbie had not decided to leave. The doctor who was going to succeed him told me about the changes he was going to make — changes which affected my department and for a number of reasons I couldn't accept them. The Board wrote me a most complimentary note with an enclosure — a $1000 cheque. I think I have that letter somewhere ... but not the cheque.

My Own Nursing Home

I had a few days of leisure to settle into my new apartment and be with my friends and then began to think of the future.

Sir William Osler in an address at Johns Hopkins University on February 22nd, 1915, spoke of the uselessness of men above sixty years of ag[illegible] the incalculable benefit it [illegible] mercial, political and [illegible] matter of course, men [illegible] was this statement [illegible] from Anthony [illegible] suggested it [illegible] chloroform all men at age sixty, that got me thinking.

I certainly did not wish to be chloroformed at sixty. I had a thousand dollars to spend and I wanted to establish and operate my own nursing home. I would be the lady superintendent.

I knew the house I wanted to rent. It was located on the top of a hill overlooking Davenport Road. The house had been vacant for a long time and a trust company was trying to sell it. I went to them and they told me the owner wanted to sell and not rent. I got in touch with the owner and arranged to meet him.

I was at the house before he arrived with the keys. The grass was uncut and the flowerbeds were full of weeds. Would I ever be able to restore the garden? As soon as the owner arrived, we went into the house — it was absolutely filthy, with cobwebs and crates full of rubbish everywhere.

I told him that I actually knew the house very well — friends had owned it at one time. I would put eight beds in the large living room, four on each side. I would like to have full curtains on rods between each bed. If this was not possible, I would have to buy screens.

We went upstairs. I was planning to put four beds in the large room there with curtains or screens. There were also two semi-private rooms, one small private room and then the master bedroom which would be the second private room. In this way I could accommodate 18 patients.

The owner seemed interested. We then went down to the basement, I was anxious to see the furnace and the laundry tubs. I told him I would have to be assured the furnace and the stove were in good working order. After looking everything over — electric fixtures, sinks, taps, etc. we discussed the situation.

He told me he had wanted to sell but the Trust Company was not able to find a buyer. He would rent if the amount agreed upon covered the taxes, the mortgage costs and a balance for decorating and repairs. He suggested a sum which I thought was reasonable and so accepted.

What a spree! I refused to buy anything but the best and nothing was to be charged. I went to the firms I had dealt with when I furnished the Outpost Hospitals. They agreed to allow me wholesale prices. Hospital beds, mattresses, pillows, bedding, linen, blankets, dishes and china. The thousand dollars were disappearing rapidly. I had to be careful to keep enough in reserve to pay the rent for a couple of months until there would be some patients. All was in readiness when the first patient arrived.

My First Patient

A very good friend of mine reserved the small private room for her brother. He was my first patient and he was to arrive at eight p.m. I hired a nurse for the night. She was a graduate of my own training school. He arrived and seemed satisfied with the accommodations. I said goodnight to him and the nurse and I went to my room — I was too excited to sleep.

In the morning I prepared breakfast and then called the nurse to take up our patient's breakfast tray. I didn't know why but I thought she looked rather glum.

I saw the patient later. He asked me to phone his sister — he was leaving. He absolutely refused to stay another night in the house, the nurse had been impertinent. Apparently she had told him to be quiet when he called her the night before. The second time he called she had slapped him.

What could I say? I was so sorry, I thought she would be satisfactory. His sister came for him and they left — so did the nurse.

I realized my patient was a very sick man and perhaps he had been impatient with the nurse but I could not, and would not, allow any of my nurses to treat a patient unkindly. The man died a short time later. I was glad that he had not died in my home.

Other patients arrived. Three graduate nurses living in the district had applied for work. I hired them and notified them as patients were admitted. The nurses proved to be very satisfactory.

The cook, launderers, and part-time handy man lived outside of my Home and these employees did not work out as well. The munition factories were attracting young women and able-bodied men were in the army — all in all there were not many people left to choose from.

The cook would come in one day and not the next. The woman who did the washing and cleaning was most unreliable. I do not know how I would have managed if a practical nurse had not applied. She soon came to be my right hand man.

Together we managed the washing when the launderers did not arrive. She was always pleasant to the patients and we became quite fond of one another.

She told me I was working too hard. I knew she was right and my family was very worried about me. Finally, my doctor said he would not be responsible for what would happen if I didn't sell or give the place away

I was heartbroken. Everything had been going so well, the beds were nearly always occupied. I wasn't making a great profit, but I was not in debt.

One evening the night nurse told me that if I was thinking of discontinuing the home (they all seemed to think I was done for) she would like to take it over. I sold her all my wonderful equipment .... everything but the furniture I had brought from my home.

I asked my lawyer to prepare a statement for me. He was really upset — why didn't I consult him? I had priced things far too low and I had made no allowance for the reputation of the home, its good name. But nothing mattered to me at that point. I just wanted to get away. My dream was over.

I moved into my small apartment in the duplex we had built. I did not enjoy resting and

relaxing. It only served to make me realize to what a great extent I had neglected myself. I had been too impractical.

I sat at home and twiddled my thumbs for several months, I kept thinking there had to be something I could do. The longer I sat, the more frustrated I became.

One day I met a friend of mine (a Sick Children's Hospital graduate) for tea. She was still working and was planning to ask for a month's holiday. She had to find someone to relieve her.

"Lilly, would you suggest me? I am so anxious to be doing something."

Lilly arranged everything with the Superintendent of Nurses at Sick Children's.

I was working in the children's dress department. Those patients who were well enough to get around could come in and choose the dress they liked. The brighter the material, the more the children liked it — nothing was too gay.

I loved working with the dear little tots. Their faces would glow with pride and their eyes would sparkle brightly as we tried the dresses on them. I was sorry when the month was over.

I went to the Superintendent's office to tell her just how much I had enjoyed the work. She told me she was planning to have a small room set apart as a Private Patients' Waiting Room and she needed a Nurse/Receptionist to supervise the area. Attending physicians were often very busy men and they were not always available in their offices. As the receptionist, I would call the pediatrician and care for the baby until he came. I accepted the position and stayed with the hospital for three years.

One day a woman and her husband appeared at the door, she was weeping over a frail little babe in her arms. I took the baby from her and rang frantically for the doctor. I rang and rang but when he came I handed him a lifeless little body. The baby had died in my arms. I was terribly shaken. I have never forgotten that feeling of the child dying so close to me.

The Emergency Department was right next to the waiting room. When I wasn't too busy I would have coffee with the nurses. They were all very friendly. Before I left they had a farewell party and, much to my embarrassment, they gave me a lovely little gold pin which I value greatly.

When I cashed my final cheque I had been gainfully employed for 47 years, from 1912 to 1959. I don't think that at 79 years of age anyone would question my decision to retire.

I began to be plagued by blackouts early in 1962. I was repeatedly admitted to the hospital for a few days and then discharged only to await another attack.

My doctor advised a move into a guest home where I would not be alone.

I knew he was right but I did hate parting with my things, some I had brought from abroad, some from mother's and grandmother's home. It's hard to leave things that have been with you for so long.



It is nearly midnight November 28, 1972. I find myself watching the clock and recalling my experiences of the past ninety years.

The doctor has told me I'll have to return to the hospital sometime soon. I'm wondering how I can use the leisure time I will have there? How can I use it to its best advantage?

Then I'm reminded of a verse in one of Oliver Wendell Holmes' poems: *"If I should live to be the last leaf on the tree in the spring, Let them smile, as I do now, at the old forsaken bough, where I cling."*

Mr. Holmes you have helped me solve my problem.

I will write of those adventurous ninety years, so many of them spent nursing, and show that true adventure knows no age, era or profession.

My story will be called "Four Score and Ten."

A SCHOOL SCREENING PROGRAM THAT WORKS

Between 1974 and 1976, school nurses in Montreal screened 26,947 children in grades seven and eight for adolescent idiopathic scoliosis. Of these, 4.6% had scoliosis positively diagnosed by radiographic examination; 4.5% were idiopathic in nature. The nurses were part of the Shriners School Scoliosis Program — a program that has proven to be a clinically sound, cost effective way of detecting early scoliosis, providing consistent follow-up and treatment and preventing progression of the condition. What follows is a description of how cooperation and planning among existing health institutions can make a preventive program work.

Jean F. Gurr

Three years ago, medical consultants at the Shriners Hospital for Crippled Children and at McGill University along with school nurses from the Department of Community Health at the Montreal General Hospital got together to establish the Shriners School Scoliosis Program. The program's objective is to demonstrate the clinical effectiveness and low cost of an organization that focuses on early detection of adolescent idiopathic scoliosis accompanied by thorough and consistent follow-up and treatment. The team of health professionals working in the program also keeps records of the incidence of the disease, its natural history and from these, seeks to demonstrate how follow-up and conservative treatment can prevent progression of a curve to 60°, thereby decreasing or eliminating the need for surgical intervention.

The program requires a well established community health unit with competent nurses working in a broad sample of secondary schools. This must be complemented by a fully equipped medical center with a coordinated backup service (medical consultant, nurse, secretary, radiographer, and physiotherapist). (See figure 1) Adequate transportation from the schools to the medical center is also important. All of these requirements were made available to us in the Montreal area.

The full cycle of the program consists of four phases:

- inservice education
- school screening
- follow-up and treatment
- documentation and evaluation.

Implementation of these phases is the responsibility of the program's coordinator. It is her job to coordinate the diverse functions of the team (See figure 2). In addition, by communicating with the various departments at the medical center, she is able to obtain cooperation from other members of the team, (e.g. radiology, medical records, and physiotherapy), cooperation essential for the smooth running of the program.

Inservice education

Small groups of school nurses chosen by the Department of Community Health are given inservice education prior to the implementation of the scoliosis screening program in the schools. The coordinating nurse helps to organize and prepare the training sessions while the medical consultant presents the program and its objectives. The training sessions emphasize the importance of the nurses' role in the total program and demonstrates the screening procedure to be used.

FIGURE 1 ORGANIZATIONAL STRUCTURE

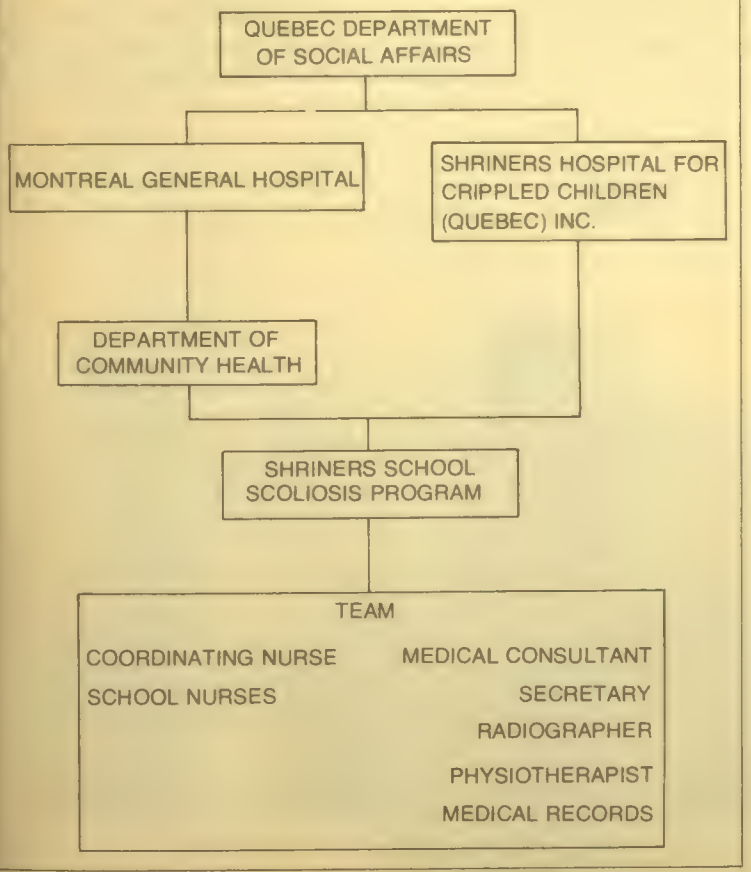


FIGURE 2 COORDINATION CHART

TEAM COORDINATION	FOLLOW-UP CLINIC	BRACE CLINIC	SCREENING CLINIC	MOLD FOR JACKETS	HOME VISITS	INSERVICE
OUTPATIENT DEPT.	X	X	X			
ORTHOTIST		X		X		
DEPARTMENT OF COMMUNITY HEALTH			X			X
RADIOLOGY	X	X	X			
MEDICAL CONSULTANT	X	X	X	X	X	X
ADMINISTRATION	X	X	X		X	X
SCHOOL NURSE			X			X
BUS COMPANY			X			
PATIENT	X	X	X	X	X	
O.R.				X		
PHYSIOTHERAPY		X				

As an educator, the school nurse is expected to pass on this information to the school and the community. She does this through conferences with school staff, student groups and information letters to parents. Obtaining support from the community at an early stage is important since the success of the program and its follow-up will in large part depend on the understanding, cooperation and acceptance of the program by these people.

School screening

There are a number of significant features of scoliosis which we used as the medical criteria for the development and implementation of our School Scoliosis Program:

- Idiopathic scoliosis is structural in nature and accounts for 65% of the disease incidence.
- Adolescent idiopathic scoliosis usually manifests itself before the final "growth spurt" or at the "modesty age," when parents do not see their children undressed.
- Scoliosis curves are classified as thoracic, thoracolumbar, lumbar, and double major curves. The apex of most thoracic curves is to the right and the apex of most lumbar curves is to the left. Scoliosis curves are further classified as infantile, juvenile, and adolescent depending on the age of onset. (See figure 3).
- Rotation of the vertebrae causes a rib hump which may be observed clinically.
- Small curves (under 15°) usually remain stable with the establishment of skeletal maturity.
- Thoracic curves of 45° or more, and lumbar curves of 36° or more, may continue to increase at the rate of 1° per year, even after maturity. This often results in pain, deformity, possible diminished cardiac output, and diminished pulmonary reserve.
- Idiopathic scoliosis tends to be a familial condition.
- Treatment using a brace is prescribed for curves between 20° and 30° where there are definite signs of progression and skeletal immaturity. For curves over 30° where skeletal immaturity exists, treatment is prescribed without waiting for progression. Other data such as age, height, family history, radiological measurement of ossification of the iliac apophysis, vertebral rotation, and the onset of the menarche help to determine the progression potential of each child.
- A structural curve measuring 6° or more by the Cobb method was used as the criteria for diagnosing idiopathic scoliosis.

Using this medical criteria, the most productive and safe age level for screening is with 12 or 13-year-olds, usually grade seven or eight. (The productivity rate of a trial screening at the grade six level was found to be low).

Primary screening is carried out by the school nurse in the school. The technique is simple and takes only a minute. The child undresses to the waist and stands in front o the nurse. The nurse makes her first observation from the back noting any asymmetry of the torso such as shoulder, hip or scapula levels. With scoliosis the shoulde and scapula on the convex side of the curv tend to be higher. Likewise, the hip on the opposite side of the curve may be more prominent at the waist. As well, the arm on th convex side of the curve will be closer to the body. Keeping in mind that the apex of mos thoracic curves is to the right and most lumba curves to the left, it is sometimes possible t see the actual deviation of the spine (See figure 4).

The nurse then asks the child to bend forward from the waist with feet together, knees straight, head and arms falling freely, and hands clasped together. Keeping her eye level with the child's back, she looks for any difference in elevation of the rib cage (See figure 5). This "hump" on the convex side o the curve is the most indicative sign of a possible scoliosis, and is due to rotation of th vertebral bodies toward the concavity of the curve (See figure 6).

All clinical observations are recorded b the nurse. Among the children screened, a number will be observed to have only a suspicion of abnormality. The nurse must use

FIGURE 3

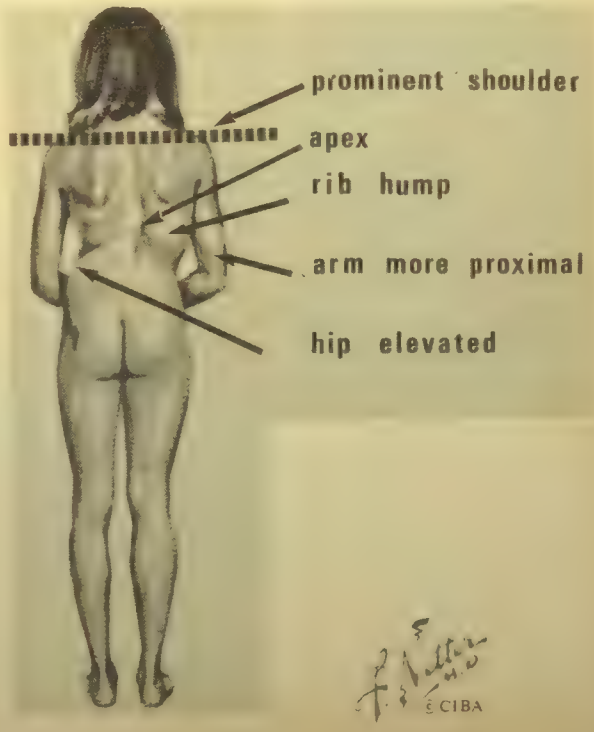
Classification of Scoliosis

NON-STRUCTURAL SCOLIOSIS: a curve with no fixed rotary components and totally correctable by bending to the convex side, by lying down or by traction. The causes are poor posture, a leg length discrepancy, inflammation or hysteria.

STRUCTURAL SCOLIOSIS: a curve with fixed vertebral and rib rotation.

1. **Idiopathic:** about 65%
   (a) infantile — 0-3 years
   (b) juvenile — 4-10 years
   (c) adolescent — 10-maturity
2. **Congenital:** about 15%
   Vertebral anomalies, eg. myelomeningocele, wedged vertebrae,
   Extravertebral anomalies — hemi-vertebrae, fused ribs
3. **Neuromuscular:** about 10%
   (a) Neuropathic — eg. cerebral palsy, poliomyelitis, neurofibromatosis
   (b) Myopathic — eg. muscular dystrophy
4. **Mesenchymal Disorders** — eg. Marfan's syndrome, Scheuermann's disease
5. **Trauma** — eg. fractures, irradiation, burns
6. **Infection** — eg. tuberculosis
7. **Metabolic Disorders** — eg. rickets
8. Others — nutritional, endocrine.

FIGURE 4
CLINICAL CHARACTERISTICS



her judgment in such instances, and maintain a file on these children for follow-up within the school year. We feel that it is unwise to load the referral lists with large numbers of suspicious cases which tax the medical center facilities and do not benefit the child. Nonetheless, the nurse has a professional responsibility to provide for follow-up services if she still suspects an abnormality during later observation.

Upon completion of a school screening, the nurse summarizes her findings and then contacts the parents of all children she feels should be seen by the medical consultant. This is normally done by telephone. She reassures the parents, and answers all questions about the disease, follow-up and treatment. The parents are asked to sign a consent for radiological examination and are invited to accompany the child to a secondary screening clinic.

Follow-up and treatment

The subsequent phase of the program is carried out at the medical center and consists of three types of clinics:

1. Secondary screening clinic
2. Regular follow-up clinic
3. Brace clinic

1. *Secondary screening clinic*

Secondary screening is carried out by the medical consultant. The program coordinator arranges for a bus to transport the children, school nurse and interested parents to the medical center for this clinic. The school nurse participates in the secondary screening and is therefore able to evaluate her own visual screening ability. Age, height, weight, arm spans, and menses onset are documented. Family history is recorded along with other clinical diagnostic observations. Radiological examination, usually an A-P erect spine, is made at the discretion of the medical consultant. Using the X-ray, curves are measured using the Cobb method. Rotation of the curve is also measured and skeletal maturation is determined by using the Risser method to measure iliac cresting.

The children see the X-rays and for the first time discuss their curve with the medical consultant and the nurse. They are encouraged to take a positive view of the diagnosis and in particular, to assume some of the responsibility for follow-up and treatment by remembering to keep further appointments. Parents who have not accompanied their child to the medical center receive a letter from the coordinating nurse outlining the result of the examination.

2. *Regular follow-up clinic*

When the diagnosis indicates a need for follow-up treatment, the parents are once again encouraged to attend the clinic with their child (See figure 7); the coordinator schedules the clinic and advises them of the date and time. Together, the parents and the child are shown the X-rays and the medical consultant discusses and clarifies the implications of the diagnosis with them (See figure 8).

Further clinic visits are requested by the medical consultant for those children whose curves have not yet stabilized. These follow-up visits are considered a vital part of the overall program. The coordinating nurse ensures that follow-up is carried to completion by tracking down children who miss clinics and rescheduling their clinic appointments.

FIGURE 5
SCREENING FOR RIB HUMP



FIGURE 6
A MINIMAL CLINICAL RIB HUMP



FIGURE 7
PARENT PARTICIPATION



FIGURE 8
IMPLICATIONS OF DIAGNOSIS



3. *Brace clinic*

Progressive thoracic curves and thoracolumbar curves are treated with a Milwaukee brace (See figure 9) while a lumbar curve is treated with a McEwan (molded) jacket (See figure 10). They must be worn 23 hours a day until skeletal maturity develops. These braces as well as others such as the Boston Orthosis act as holding devices to arrest the progression of the curve. Although body braces rarely reduce the size of a curve, these orthoses when accompanied by physiotherapy have had highly effective results. Today the only acceptable treatment for idiopathic scoliosis begins with the early detection of the curve followed by prevention of progression using these orthoses.

When a curve has progressed to a stage requiring conservative treatment, the medical consultant immediately talks this over with the parents and child. Whether the child accepts or rejects the brace depends largely on how much support he will receive from his parents. In turn, their support depends on how well they understand their child's problem. Both the parents and the child need a full explanation by the medical team of the treatment and its outcome .

All children undergoing treatment return to a Brace Clinic every three months. This gives the medical consultant the opportunity to check that treatment is progressing as planned. Additional X-rays are taken every six months to establish the status of the curve and iliac excursion (an indication of skeletal maturity). At each visit an orthotist checks the brace for comfort and fit and provides his expertise for brace adjustments. As well, the children visit the physiotherapist who outlines and supervises a regime of exercises. At subsequent visits, the importance of activity and the maintenance of good muscle tone is reinforced.

Brace clinics are organized so that all children undergoing treatment meet each other. The nurse's role during this phase is to help the children solve personal problems associated with bracing. Loss of self-image, dependency, frustration, difficult adjustment to lifestyle, and changing relationships with parents and peers are all conditions which can occur. The nurse is also a source of guidance for physical problems involving skin care and personal hygiene.

During our two years of operation, participation in the clinics have given the medical team a chance to observe how children and their parents react to scoliosis and its treatment. Generally, these observations have been confirmed in the literature by others who have studied adolescents undergoing conservative treatment.

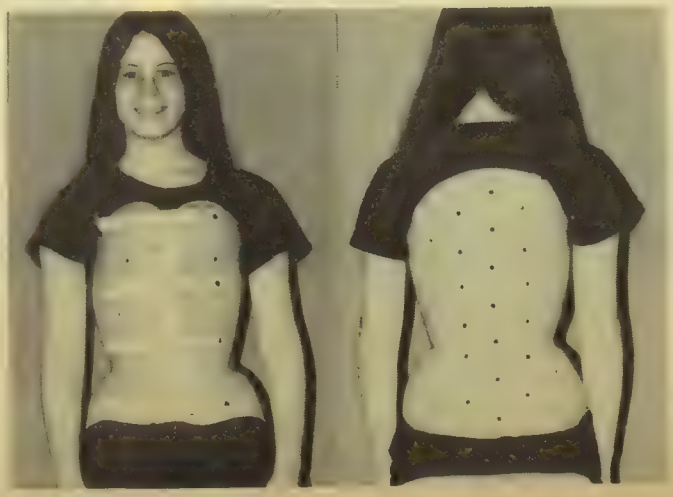
We have found that children at the adolescent stage fluctuate between the desire for independence and a basically unexpressed need for parental support. Often, parents are not sensitive to the fluctuations between these needs. Children frequently come to the clinics by themselves and display feelings of apprehension or indifference. Because the coordinating nurse and the medical consultant recognize these feelings, they encourage the children to take a positive outlook by talking with them in a friendly and supportive way. As much as possible, they are encouraged to recognize that they are not ill and are to remain active.

The decision to use a brace is always upsetting for the parents and the child; most parents express feelings of guilt and the child a sense of despair. We have found that young people either fully accept the prescribed treatment, adopt a mature outlook and maintain their self-respect, or they reject it completely. At this early stage, good communication skills are required by the medical team. Children and their parents need to know that they can talk about their feelings with the staff. At our clinic, many children seeking support and reassurance phone the nursing coordinator "just to talk."

FIGURE 9
MILWAUKEE BRACE



FIGURE 10
MOLDED JACKET



Evaluation and documentation

At the end of the school screening program, the school nurse documents her yearly statistics. From these, she is able to evaluate her screening proficiency.

Data from a sample of 20 schools, chosen at random from the program in 1975-76, showed that the school nurses had an average screening productivity of 86%. Of the 3,481 children screened, 352 were referred for secondary screening at the medical center, and 65 others selected private referral. Of those referred to the center, 58 had a suspicion of scoliosis, 149 had curves measuring 5°-10°, and 89 had curves measuring over 10°. Five of the 89 are now being treated with braces. Eight had diagnosis other than scoliosis, such as leg length discrepancy and Scheuermann's disease (kyphosis). Forty-eight did not require follow-up.

Screening proficiency was a large factor in one nurse's ability to observe a child with a rib hump, an indication of a possible early case of idiopathic scoliosis. Radiographically, the curve was minimal, yet, it progressed rapidly into the treatable range.

Once the school nurses have documented their statistics, these are collected by the nursing coordinator of the program and the secretarial staff who then prepare yearly statistics. Medical records are kept for each child using a key sort card. Information from progress notes that includes data such as family history, curve classification, rib hump, rotation, cresting, menses onset, other orthopedic problems and prescribed treatment are noted on the card. These cards are updated after each clinic visit.

A cost analysis was prepared by the coordinator based on data from a sample of 400 school children. This exercise compared the cost of screening and conservative treatment against the potential cost of surgical treatment. Because of our strict criteria for conservative treatment, we assumed that most progressive non-treated scoliosis would ultimately require surgical intervention. The total cost of all phases of the screening program for the 400 children was approximately $1,700. For the same group of children, a 2.75 per thousand surgical rate was calculated to cost some $11,000.

Results

From the records covering the two-year period (1974-1976), in which 26,947 children were screened under this program, the following summary of major medical statistics has been prepared:

- 4.6% of the 26,947 children screened had scoliosis; 4.5% were idiopathic, positively diagnosed by X-ray as structural curves and over 6°. There was a 2% incidence of idiopathic scoliosis with curves greater than 10°.
- The female to male ratio of scoliosis was 1.25 to 1, female predominant.

A HAPPY SECURE ATMOSPHERE IS SOMETHING THE MEDICAL CENTER CREATES



- In curves that were 21° or more, girls predominated by 5.4 to 1. Over a 24-month period, 2.75 students per thousand screened were treated with braces.
- In the first year (1974-75) of our program, it was estimated that the provincial health expenditure was reduced by some $347,000 for the 14,902 children screened. The aggregate return to the province included this reduction in expenditure plus the elimination of extensive shadow costs (e.g. welfare, tax loss, productivity, workmen's compensation, etc.).
- Over the two-year period, only four of the 75 children who had braces prescribed refused treatment.

Conclusion

School screening programs, such as the Shriners, are one means of applying the concept of prevention to health care. Mass screening by a school nurse who provides early and accurate clinical observations is a highly effective way of detecting adolescent idiopathic scoliosis in a significant number of children. Medical statistics confirm that the program's performance is consistent with current medical data, and is capable of providing new findings.

Because many health professionals are working together, both the physical and the emotional needs of the child and his family can be recognized and met. The use of existing facilities and institutions permits provincial and medical services to realize significant cost reductions over the long term.

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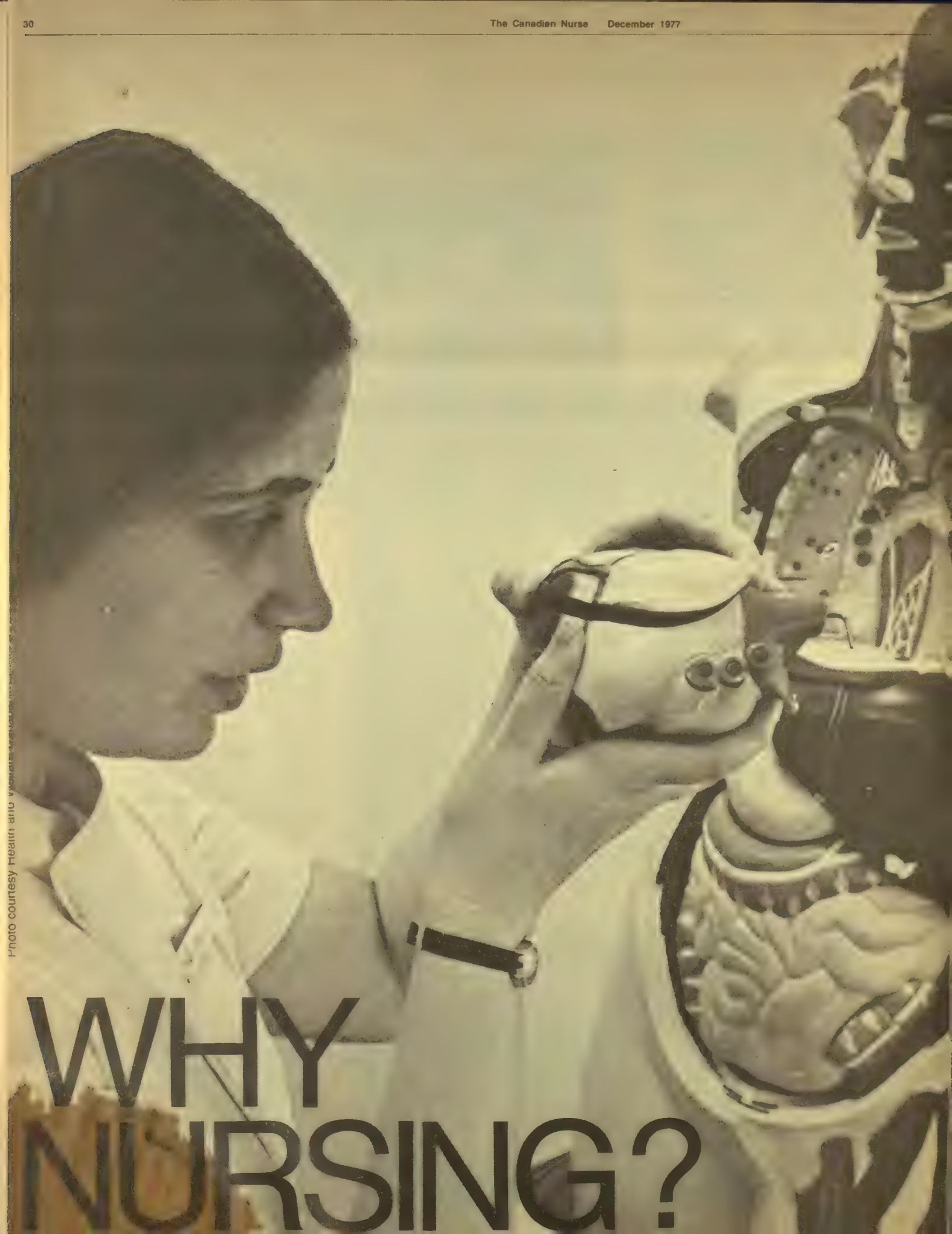


Photo courtesy Health and Welfare Canada

WHY NURSING?

OCCUPATION AND CAREER PERCEPTIONS OF NURSING STUDENTS IN NEW BRUNSWICK*

What reasons prompt young people today to choose nursing as their career? Are they influenced by the idea of working as part of a highly professional team in the health care system? Or are they, still, like many generations of nurses before them, attracted to the ideal of service to others ? If you think the old argument of professionalism versus humanitarianism is dead — read on. Not only is it alive and well in New Brunswick, it is also being reinforced by the very teaching institutions that educate our nurses.

Donald J. Loree
Irene Leckie

The choice of an occupation or career is one of the most important decisions any individual makes in the course of his or her life.

In selecting a career, several important factors are involved. First, young people must understand their own life situation and the career chances that are possible for them. Second, they must have some knowledge of what the career they choose involves, and what the practitioners in this profession do. Third, they must decide by what avenue they will enter their chosen career.

The prospective nurse in New Brunswick is confronted with two avenues of entry into the field. She can enter a Baccalaureate program in a university, or she can enter a Diploma program in an educational institution other than a university.

We recently undertook a study of the occupational and career perspectives of nursing students in New Brunswick. What struck us particularly about the findings of this study is that the choice of either the Baccalaureate or the Diploma program appears to be based on differing perceptions of the role of the nurse in today's society. In other words, the way the potential nurse defines her future role, whether she sees the nurse as a professional member of a professional team or whether she sees the nurse primarily in a humanitarian role, will affect her choice of which institution to enter.

The sample

Our questionnaire was administered to all students enrolled in schools of nursing in New Brunswick in the Fall of 1976, including Baccalaureate programs at the Université de Moncton and the University of New Brunswick as well as five independent Diploma schools.

The questionnaire was prepared in both French and English and distributed according to the language or languages of instruction at each institution. Two pre-tests provided valuable guidance in constructing the questionnaire and allowed us to eliminate some problems and also to pre-code answers to the majority of questions. This was important to achieve comparability between the English and French versions.

Demographic factors

A total of 715 nursing students (80.6 percent) completed and returned the questionnaire. More than half (60.8 percent) of these were enrolled in Diploma programs.

The remaining 39.2 percent (280 students) were enrolled in Basic Baccalaureate programs. Analysis of the information provided by these students indicated that:

- 98.5 percent were female
- 59.6 percent considered English their mother tongue*
- 95 percent were between the ages of 15 and 24 and 60 percent were between the ages of 15 and 19
- 51.5 percent came from farms or small towns with populations of less than 5000 persons.

More about our respondents

When we looked at the answers to questions we had asked about the occupations and educational attainments of their parents as well as income of the family head,[1] we found an apparent relationship between these three major socioeconomic variables and the program that the students were in. Socioeconomic levels of parents of Baccalaureate students were consistently higher for all three variables than parents of Diploma students, a fact which can be related, at least in part, to the reported differences in time and cost between the two programs.

It is interesting to note, too, that for a large percentage of students the reported education level of the mothers is considerably higher than that of the fathers. This reflects the relatively high proportion of our respondents whose mothers were either teachers or nurses.

We wanted to know what other factors might have influenced these students in their decision to enter nursing, so we asked several additional questions. In their responses the students indicated that:

- Almost three-quarters (73.7 percent of Diploma students and 74.6 percent of Baccalaureate students) had at least one relative in nursing, medicine or a related occupation.[2]
- About one fifth of the respondents (20.8 percent of Baccalaureate students and 20.4 percent of Diploma students) indicated that parents, friends or teachers in the first instance, followed by nurses or other health

*More details concerning the study on which this article is based are available from the authors at the University of New Brunswick.

care workers, had been most influential in directing them into nursing programs.

- A small but not insignificant number of students (6.4 percent) indicated that media influences were primary.
- Almost exactly half of the students (50.1 percent) reported that they chose nursing because of the opportunity it offered to serve others.

Although we found a definite correlation between the various socioeconomic variables that we examined and the program that the student enrolled in, these variables had little impact on whether the student indicated either a professional or humanitarian orientation.

Humanitarian versus Professional

The debate on the humanitarian versus the professional aspects of nursing is an ongoing one.

However, even a quick scanning of recent newspaper headlines on the subject of abortion or nurses' strikes will make it clear that, to the general public at least, the traditional image of the nurse as a caring person ministering to human suffering is still very real and very desirable.

If these kinds of concepts are present in the mind of the public at large, they cannot help but have an effect on the perceptions and decisions of those entering or considering entering nursing. While roles are primarily learned during the educational and socializing processes found in both the Baccalaureate and the Diploma programs, some awareness of the differences between the two will certainly be apparent to the observer. The potential nurse is an observer, and a very interested one, if she is considering entering the profession. She sees not only the different types of nursing education open to her, but also the different ways nurses approach their work in different settings. The choice she makes will be influenced by her observations, socioeconomic factors and her perceptions of the nursing profession and nursing roles as being predominantly humanitarian or professional.

Several writers have attempted to identify and classify the role of the nurse *vis-a-vis* the other related roles in the health field. In a study of nursing in Jamaica, Dorian Powell[3] identifies the two major images of the nurse held by the public in general *and by those entering nursing;* the traditional one stressing "humanitarian attributes," and the professional image stressing a more "technical" orientation.

Johnson and Martin[4] put forward the traditional viewpoint of role differentiation in the institutional setting. They argue that in the hospital a division of labor exists in which "instrumental and expressive functions are not participated in equally by nurse and doctor ...The doctor's role is primarily that of the detached professional and the nurse's more expressive and humanitarian in orientation. Ideally the role of the nurse would integrate some of the professional aspects so as not to upset optimum 'team' effort."

Nurses do, and are expected to, perform a variety of different functions in their activities. In the same way, nurses in different areas of a profession or institution will be expected to function in a different way from others in other areas.

In a similar vein, Corwin[5] notes that differing conceptions of nursing were found to be related to the nature of organizational goals and occupational settings. The three he noted were: the employee (basically the bureaucratic role), the independent professional, and the public servant in a humanitarian context. Corwin stresses the first two, apparently due to a concern with the administrative-bureaucratic and professional aspects of the hospital and its internal occupational relationships.

Although he refers to Diploma schools that function as part of a hospital (no longer the case in New Brunswick), Corwin does stress the differences in the orientation of the two programs. The Diploma program, he argues, is more bureaucratically oriented and the Baccalaureate more professionally oriented.

The New Brunswick Study

For the purposes of our study in New Brunswick, we delineated these two broad views commonly held of nurses:
1) the humanitarian concept, based on the traditional, stereotyped image of nurses, and 2) the concept of the nurse as an objective, rather detached, professional functioning as part of the health care system. Both of these images of the role of the nurse are predicated on different conceptions of the nurse-doctor relationship and the nurse-patient relationship. Each assumes an equal level of competence in technical nursing skills, although in each case the stress may be upon different skills. While elements of both orientations are probably a part of the general conceptualization of nursing, one image or the other will likely predominate and be more influential in determining attitudes and behavior in the individual entering nursing, and especially her choice of Baccalaureate or Diploma education.

Why Nursing? Image and Orientation

Two questions were of crucial concern in this study. First, why had the respondents selected nursing as a career, or, to be more specific, what facets of nursing had been instrumental or influential in their decision to become nurses. Second, were the reasons cited by the students in any way related to the school enrolled in? In this, we operated on the assumption that Baccalaureate and Diploma programs differed in their orientation and that this distinction would be reasonably well known by prospective applicants.[6]

Respondents to our questionnaire were asked to select from a list of possible choices and rank in order of importance those statements that most closely corresponded with their own reasons for selecting nursing as a career. The responses were divided into two general categories: those that indicated a more professional conception of nursing and those that illustrated a more traditional, humanitarian image of the nurse and nursing. The former included items such as "the image of the nurse as a medical professional appealed to me" and the latter statements such as "I wanted to help others, especially the sick and helpless."

The responses are interesting in light of current debates, trends and changes in the role of nursing and nursing education. Almost two-thirds (63.2 percent) of the students selected one of the humanitarian responses as being most important in their career choice decision. Just over a third (34.7 percent) cited one of the professional reasons first. A significantly higher proportion of Baccalaureate students than Diploma students (41 percent as opposed to 30.8 percent) cited a professional reason as being most important in their decision to become a nurse.

Although the differences between the two groups of students were minimal at the level of their third choice, these findings do indicate a somewhat greater tendency for those entering Baccalaureate programs to do so because of a professional rather than humanitarian concept of nursing and the nurses' role. Diploma students, on the other hand tended to have been much more influenced by the humanitarian aspects of nursing as indicated by the fact that two thirds (67.4 percent) of them cited a humanitarian reason as being most important as opposed to just 56.8 percent of the Baccalaureate students.

In other words, these findings indicate that while humanitarian perspectives were found to be held by a majority of students in both programs, a greater proportion of students entering the Baccalaureate program are oriented towards and hold a more professional conception of nursing than those entering Diploma programs. What the data also indicate is that Baccalaureate schools are considered to be more professional in orientation than Diploma schools.

Career Perceptions

If these differences are important, one would expect to find that the expectations and hopes of the Baccalaureate and Diploma students about their future career in nursing would also differ in similar respects. This expectation was indeed supported to a considerable degree by the responses to other items on our questionnaire.

Students were asked to indicate what nursing positions they expected to obtain on graduation and what positions they ultimately hoped to attain. Far fewer Baccalaureate

students expected to start in that most traditional beginning position — staff nurse. Even fewer, when compared to Diploma students, expected to remain there. The major steps of expected mobility within the profession, as seen by Baccalaureate respondents, were in those areas that could be defined as having a more "professional" connotation: head nurse, supervisor, instructor or administrator. Very few Diploma students expected to achieve these positions. Among the Diploma students, the main area of mobility was in the "special area" category, followed by "community".

Our figures lend support to the contention that students entering Baccalaureate programs do so with somewhat different expectations of their nursing career than those entering Diploma programs ... expectations reinforced by the programs themselves. If the career possibilities are seen in terms of "professional" versus traditional "humanitarian" categories, the expected and anticipated career patterns of Baccalaureate students show a marked tendency towards the former and those of Diploma students towards the latter. In each case, the responses probably reflect a realistic interpretation of the career patterns available or apparent to those with Baccalaureate degrees and to those with Diplomas in nursing. Part of this is certainly due to the nursing education and socialization processes experienced in the two types of programs. However, part must also be attributed to a degree of common awareness of the realities of career patterns within the nursing profession, by nurses, students and the public at large.

Summary and conclusion

Our data strongly suggest that prospective nursing students perceive Diploma and Baccalaureate programs differently.

Service to others and an overall humanitarian perspective was indicated by a majority of students surveyed but there were also many who expressed a professional orientation towards nursing. A significantly greater proportion of Baccalaureate students than Diploma students were among the latter group. The most likely explanation of this lies in the differing images and role models presented by the two types of programs and their graduates.

The relationship between program and orientation towards the nursing profession was given additional support by data which indicated that Baccalaureate and Diploma students also perceived their future career in nursing, their nursing role, rather differently. Occupational and career goals and expectation patterns, both short and long term, reflected recognition by students of the relationship between their preparation and career possibilities. Although this is undoubtedly due in part to the socialization experiences, formal and informal, of the nursing education process, it must also be partly dependent upon the images of nurses and nursing, that the student held prior to enrolling in a particular program. These images have, as shown previously, considerable impact upon the type of program selected by the individual.

As the nurse's role changes we would expect to see alterations in images and orientation of the profession held by both nurses and the general community.

The specific direction which will predominate, will depend very much upon the type of changes which occur in the nursing role and relationship with other health professionals.

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**In New Brunswick, French is considered the mother tongue of roughly 40 percent of the population.*

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Catching a plane to go to work is all part of the job for the occupational health nurses who work at the Wollaston Lake Uranium mine, 446 air miles northeast of Saskatoon. Working stretches of eleven hours a day (or more) for seven days at a time provides the nurses with busy, exciting and unpredictable schedules. Author Janet McIvor, a nurse who worked in this setting, shares some of her experiences with us.

Flying to work

Janet McIvor

The Wollaston Lake open pit uranium mine, operated by Gulf Minerals Canada Limited, is typical of what is happening in Saskatchewan's mineral rich north. Along with local workers from nearby Black Lake, Fond du Lac and Stony Rapids, the company employs workers from the areas around Uranium City, Prince Albert and Saskatoon and flies them to the mine site on four weekly chartered flights.

All 250 or so employees (including the nurses) work an eleven-hour day, for seven days and then are flown back to their homes for seven days off. The work force is housed in trailers while at the mine site since there is no town nearby.

Team approach

Since the first days of the mine's operation, there has been an occupational health team to serve the health needs of the workers. The team, whose members alternate week to week, consists of a nurse, a radiation technician, a safety officer, and company physicians in Uranium City, Prince Albert, and Saskatoon who can be contacted by telephone at any time. Work shifts overlap to ensure continuity and ongoing communication about health matters.

The company physician from Saskatoon goes to the mine site biannually to do complete physical examinations. The nurse takes venous blood samples which are sent to Saskatoon for hematology, biochemistry and other tests as prescribed by the physician.

The safety officer is responsible for mill and mine site safety inspections. There is on-going communication between him and the nurse regarding observations they have made on "formal" and "informal" tours.



The radiation technician monitors radiation levels by taking air and dust samples. These levels are calculated and given to the nurse who charts and calculates cumulative working levels for each individual employee. If an employee's radiation working level is found to be nearing a maximum level, the nurse alerts the safety officer, and the worker is pulled from the area until it is safe for him to return.

A working day

The nurse's day starts at seven a.m. and usually ends at seven p.m. although she is on 24-hour-call for the seven days at site. After seven p.m., supervisors who have first aid certificates attend to minor cuts and abrasions, but the nurse is always on call and available by telephone or two-way radio.

Nursing in this occupational health setting is varied, interesting and unpredictable so there is really no such thing as a typical work day. However, there are the more routine tasks to be done: treating frequent ailments such as colds, gastrointestinal disturbances and minor cuts; preparing the daily report which lists information about the health status of ill workers; and taking preventive health measures including audiograms, and urine collection for fluorometric analysis, a test for uranium in the system. These urine samples are collected monthly from all the employees. The nurse tests the urine for protein with a dip stick and after recording the results, splits and tags all urine specimens with a sample number before packing them for air shipment. The samples are then sent to Mississauga, Ontario, Pittsburgh, PA., and a laboratory at the mine site for fluorometric analysis.

As often as possible the nurse goes on "mill rounds". These prove interesting to say the least and provide a good opportunity to do informal teaching over a cup of coffee with the "guys" regarding radiation levels, safe working habits, etc. Besides the teaching



Ensuring proper use of respirator.



Proper use of gloves, respiratory, eye, and face shield in mill shop.



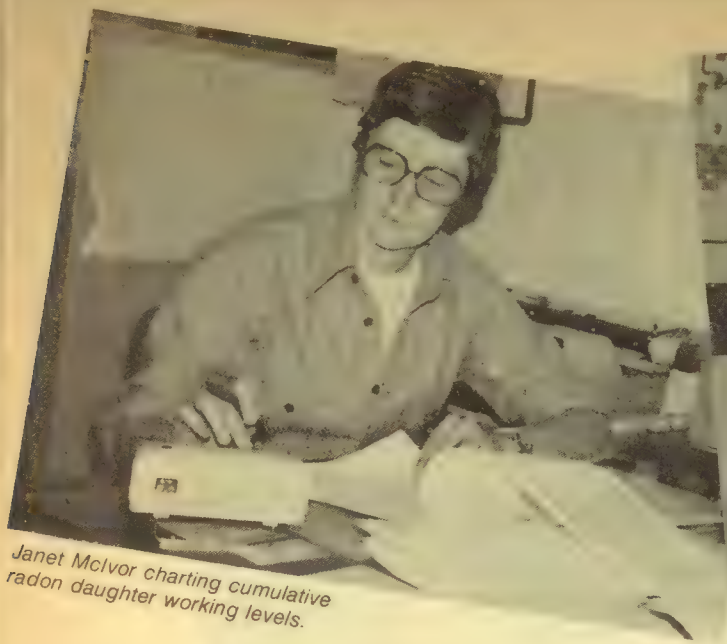
Nurses Lynda Sallis and Janet McIvor discussing working level exposures.



Testing urine to be sent for fluorometric analysis.



Conversing with fork lift operator in m



Janet McIvor charting cumulative radon daughter working levels.



Nurse, Janet McIvor and Safety Officer, L. Blair, checking extraction levels in control room.

aspects, this is a good time to watch for safety hazards such as oily, greasy rags left lying around, slippery floors and catwalks, improperly blocked equipment in the garage, improper use of respirators and disposable clothing. The nurse can then pass on these observations to the safety officer.

If a worker requires emergency care such as suturing, this is done by the nurse on site. Employees who are sick in bed are visited at least twice daily by the nurse and, if necessary, the physician can be consulted by telephone for medication orders. Medication supplies are kept in the health center and an ambulance is always available. If an employee should need further medical attention on days when there is no charter flight, a plane is called to come to the site and fly the worker to the nearest hospital. When a plane is required after sundown, flares have to be placed on the gravel runway since there are no runway lights.

Cancer link

Perhaps the nurse's most important function is to keep a close watch on the length of time workers are exposed to radon gas and radon daughters, the by-products of the mining and milling process. These by-products are odorless, colorless, and tasteless and can be hazardous to the health if proper preventive measures such as hand washing, proper use of respirators in designated areas, proper use of disposable clothing, and limiting of exposure times are not carefully observed.

Evidence has been put forward linking lung cancer with these by-products so work areas are monitored very closely and employee education stressing preventive measures is important.

Counseling

Counseling takes up a large part of the nurse's day. Topics often range beyond health issues and frequently workers visit the nurse to talk over problems related to separation from family for seven days and associated worries regarding the wife's ability to cope with family and financial responsibilities during this time. Other problems discussed include job stresses, alcoholism, and financial responsibilities.

On one occasion it was necessary to dust off an obstetrics text to help allay the anxieties of an expectant father. Referrals are made to family physicians and/or community agencies as necessary.

To help keep the nurses up-to-date, company-sponsored continuing education such as courses in audiometrics, radiation and alcoholism are available. The nurses will also have a hand in instructing courses in radiation safety and first aid.

Nursing at a mine site in the North is certainly not for everyone, especially those who prefer a more conventional lifestyle. During her time at the site, the nurse must be prepared for the unexpected — everything from jumping in a helicopter to attend an injured man in a bush camp, to keeping an eye on a hungry bear that stays under her trailer in the pre-blueberry season.

But in spite of the frustrations, this is one area in which nursing is playing a unique and vital role. Much has been done and much more will be done to ensure the health and welfare of the workers in this northerly region.

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Pre-audiometric ear examination.



Teaching mine mechanic the use of face shield.

Clinical Wordsearch no. 9

This is another in a continuing series of clinical wordsearch puzzles relating to different areas of nursing, by Mary Elizabeth Bawden (R.N., B.Sc.N.) who presently works as Team Leader in the Rheumatic Diseases Unit, University Hospital, London, Ontario.

Solve the clues. The bracketed number indicates the number of letters in the word or words in the answer. Then find the words in the accompanying puzzle. The words are in all directions — vertically, horizontally, diagonally, and backwards. Circle the letters of each word found. The letters are often used more than once so do not obliterate them. Look for the longest words first. When you find all the words, the letters remaining unscramble to form a hidden answer. This month's hidden answer has five words (Answers page 48).

S P I N A B I F I D A A E R O H C
I U H E R P E S Z O S T E R A I T
V C B P U P I L S I S Y L A R A P
A I N D H T A E H S N I L E Y M G
R M E S U C O N C U S S I O N N T
G O R S K R L A C S E Y E E I O L
A N V E S P A L V P R R Y T N L O
I O E C N A E L A I U I A U U M S
N T M S O I G U H N Z N S K S A R
E U O B P S N D U A I G S L S R E
H A T A R A I E H L E O A U E G M
T S A N D H N M E C S M R A C O I
S T M I A P E Y O O D Y A B I L E
A U R A E A M M S R G E U T N E H
Y P E R H E A C K D L L E O O Y Z
M O D B D X E L F E R I X U L M L
F R O N T A L L O B E A F S C P A

1 Among other things, it keeps the ears apart. *(4)*
2 Pertaining to the outer covering of the brain and spinal cord. *(9)*
3 That part of the central nervous system extending from the foramen magnum to the level of the third lumbar vertebra. *(6, 4)*
4 Loss of the ability to move parts of the body. *(9)*
5 Junction between two neurons where transmission of nerve impulses takes place. *(7)*
6 Long outgrowth of the body of a nerve cell which conducts impulses from the body toward the next neuron. *(4)*
7 Involuntary and irregular movements seen in nervous diseases such as Huntington's. *(6)*
8 Destroying the myelin sheath of nerves. *(13)*
9 The cutaneous area developed from a single embryonic somite and receiving the greater part of its innervation from a single spinal nerve. *(9)*
10 A localized infection producing serious neurological effects. *(5, 7)*
11 Bony brain case. *(5)*
12 An extravasation of blood beneath the dura mater. *(8, 9)*
13 Amyotropic lateral sclerosis. *(3)*
14 Disease characterized by presence of fluid-filled cavities in the substance of the spinal cord with destruction of nerve tissues. *(13)*
15 Congenital defect in the vertebra of the spinal column. *(5, 6)*
16 Pertaining to spasms characterized by alternating contractions and relaxations of muscles. *(6)*
17 An X-ray procedure in which radio-opaque dye is injected into the subarachnoid space of the spinal column. *(9)*
18 Chronic disease characterized by muscle weakness probably due to a chemical defect at the myoneural junction. *(10, 6)*
19 Results from banging your head against a brick wall. *(10)*
20 Often brought Julius Caesar down to earth. *(8)*
21 Part of the hind brain. *(7)*
22 Sounds like figures in a chess game. *(4)*
23 A form of pre-senile dementia. *(9)*
24 Substance around nerve fibres such as axons, which speeds the transmission of impulses. *(6, 6)*
25 Disease caused by the chicken pox virus and characterized by vesicular eruption along the distribution of a sensory nerve. *(6, 6)*
26 An automatic response to a given stimulus. *(6)*
27 A cordlike structure conveying impulses from one point of the central nervous system and some other region of the body. *(5)*
28 Defect or loss of the power of expression by speech, writing or signs or of comprehending written or spoken language due to injury or disease of the brain centers. *(7)*
29 A convolution on the surface of the brain caused by the infolding of the cortex. *(5)*
30 Anterior portion of the cerebrum. *(7, 4)*
31 Cerebral vascular accident. *(3)*
32 Cerebral spinal fluid. *(3)*
33 Transient ischemic attack. *(3)*
34 The normal state of slight contraction of all skeletal muscles. *(5)*
35 Partial or nearly complete unconsciousness. *(6)*
36 A state of profound unconsciousness. *(4)*
37 May be constricted or dilated. *(6)*
38 Portion of the nervous system which is functionally independent. *(9)*



SPOUSES NEED NURSES TOO

"My wife and I have been married for 44 years. I don't remember life without her."

"He was in so much pain, he looked pitiful."

The husband/wife relationship is unparalleled by any other in our society. What happens to this team when one member is separated from the other and then placed in an alien environment under the care of strangers? Many spouses experience considerable stress when a husband or wife undergoes surgery; yet, they receive only minimal nursing care. Why?

Mary Cipriano Silva

Many books and articles have been written about the needs and nursing care of surgical patients; yet, little is known about how surgery affects families. Recently, as part of a research study, I talked with 48 spouses (32 men and 16 women) whose husbands or wives were scheduled for major general surgery not expected to be malignant. These spouses ranged in age from 22 to 70, and in years of schooling from 10 to 25. Despite these individual differences, they reported similar stressful feelings associated with surgery — feelings of isolation, anxiety, timelessness and disruption.

"We have never been separated"

One of the first things I found was that, almost without exception, a sense of isolation characterized the 48 spouses in my study. Most of these spouses reported feeling ignored right from the time of surgical diagnosis to the patient's return to the unit following surgery. For example:

- Surgeons spoke with only 6 of the 48 spouses prior to the patient's hospitalization. Nurses spoke with none of them.
- The afternoon/evening before the patient's surgery, 42 of the 48 spouses told me they had not received any information about the patient's hospitalization or surgery from any hospital personnel.
- 31 of the 35 spouses who remained at the hospital while patients were in the operating and recovery rooms reported that no hospital personnel talked with them during this period.

"I could run into the surgeon and I wouldn't know who he was." "My husband has had surgery before, but this is the first time anyone has ever paid any attention to me." Comments such as these are heard frequently and they are another indication of spouses' isolation from the health care system.

Apart from the seclusion imposed on them by the health care system, spouses experienced another type of isolation — lack of support from (or unavailability of) significant others. Although several people were accompanied by family, friends or clergy while the patient was in the operating room and recovery room, the majority of spouses waited alone. Many said they spent their waiting hours "reading," "unravelling a sweater," "trying to watch television," "praying," "pretending to write," "whittling a piece of wire" or "watching the clock."

Fear of separation from, or loss of, their marital partner was another source of anxiety for some spouses. One woman, 59 years old and married for 31 years, stated that she had never been separated from her husband, except during childbirth. Another, a 65-year-old retired executive said, "My wife and I have been married for 44 years, I don't remember life without her." A third spouse explained, "My wife is all I've got. I couldn't live without her."

"What if something goes wrong?"

Thirty-six of the 48 spouses in this study were pretested the afternoon/evening before the patient's surgery with the State Anxiety Inventory. This is a self-report scale which measures situational anxiety.[1] Spouses' scores on this Inventory suggest that two commonly held but opposing opinions about spouses' reactions to surgery may not be correct.

The first opinion often expressed by nurse educators is that surgery is always anxiety-producing for patients and their families. However, my results show that 13 of the 36 pretested spouses were not particularly anxious: that is, their scores on the State Anxiety Inventory were typical of individuals tested under nonstressful conditions. (Similar results have also been found with presurgical patients).

The second popularly accepted opinion led a variety of professionals to ask me, "Why are you studying spouses? They're not anxious." However, data from this study indicate that:

a) the majority of pretested spouses were anxious (23 of the 36 pretested spouses had State Anxiety Scores above the established norms for nonstressful situations)

b) the average State Anxiety Score for pretested spouses was higher than the average State Anxiety Score for preoperative patients as reported in other studies.[2,3]

In other words, presurgical spouses appear to be more anxious than presurgical patients.

"Anything can happen at anytime in the operating room."

It became important for me to find out just when during the surgical experience spouses are most anxious. To answer this question I waited until after the first postoperative day and then gave each spouse a list of eight time periods. I asked them to indicate which was the most anxiety-producing time for them. The time periods ranged right from surgical diagnosis to the patient's return to the unit following surgery.

What I found was that the most anxiety-producing time for many spouses was when their husbands or wives were in the operating room. A 49-year-old government executive expressed his fears quite simply, "It is the time of greatest danger." Another spouse said, "Anything can happen — anything can happen during surgery."

The wait while the patient was in the recovery room was the most anxious time for seven of the 48 spouses. "I wasn't sure everything was O.K." "My wife was in the recovery room an hour longer than the doctor said she would be."

Despite the high anxiety reported by spouses while patients were in the operating room and recovery room, these were times when spouses received little or no nursing care. Only four spouses reported any contact with hospital personnel during this waiting period.

One spouse found the wait prior to surgery particularly difficult. "The four-week wait before surgery was terrible. I kept asking myself, what if something goes wrong?" A spouse who said she was most anxious after her husband's return from surgery explained, "He was in so much pain. He looked pitiful." Other spouses remarked that had they not been prepared, they would have been "jolted" by the patient's post-operative appearance.

Personal experiences also affected spouses' anxiety levels. One man, married for 36 years said, "Before surgery my wife was terrified that she was going to die under anesthesia. She extracted a promise from me that if she died I would remarry so that someone would take care of our five children." Another man, whose wife was scheduled for a cholecystectomy confided, "My wife doesn't know how worried I am. I never told her that my father had a cardiac arrest when he had gall bladder surgery."

"A minute seems so very long."

A few spouses mentioned the sense of timelessness they experienced while their husbands or wives were in surgery. One man said, "I felt as though I were in a state of limbo."

Another remarked, "I cracked my knuckles and looked at the clock until my father came. Then I talked with him and continued to look at the clock."

This concept of timelessness has



received little attention in nursing literature; yet, it may well be a useful one in understanding the spouse's perception of the surgical experience. One nurse observed this phenomenon when her husband was undergoing major thoracic surgery. While sitting in the waiting room she soon noticed that the one question asked again and again was, "What time is it?"[4] Another nurse has described how very long a minute seems when you're waiting for a loved one's return from surgery.[5]

"My husband is home caring for the children."

It soon became obvious to me that surgery and disruption of family life go hand-in-hand for many spouses of surgical patients. One 70-year-old man who had retired early in order to care for his sick wife was unable to be admitted for surgery until after he had placed her in a nursing home. Several wives who did not drive expressed concern about their dependence on others for transportation to and from the hospital. Many patients were not visited by their spouses the afternoon or evening before surgery because their husbands or wives were home caring for their children.

Endress has studied this concept of disruption in family life.[6] In interviews with 20 spouses of hospitalized medical-surgical patients, she found that all of them reported at least one disruption in their family's daily routine. The activities most frequently disrupted for spouses were preparing and eating meals, returning from work, doing housework and buying groceries. The routine most frequently disrupted for children was bedtime.

The Problem

I looked at the data and concluded, quite simply, many spouses experience considerable stress when a husband or wife undergoes surgery; yet, they receive only minimal nursing care. Why? Certainly nurses' attitudes toward families affect their view of whether they see families as legitimate recipients of nursing care. Unfortunately, nurses frequently regard the family as an unwelcome hindrance, a nuisance or an inconvenience.[7]

One factor contributing to the negative attitude some nurses have towards families is the commonly held belief that the patient — not the family — is ill. This belief immediately establishes a set of priorities in which families can be easily, and justifiably, excluded from receiving nursing care.

Yet, there is considerable evidence to indicate that illness of one family member frequently impairs the physical or mental health of others.[12-14] In this study, for example, one wife told me she had a knot in her stomach for several days before her husband's surgery. A patient told me that her husband was unusually quiet and had tears in his eyes the day before her hospitalization. Two other women said their husbands were so "terrified" of hospitals they were unable to visit them the evening before surgery. These examples support Anthony's assertion that, "To some extent, the family is always sick along with its sick member — sometimes physically, sometimes psychologically and often empathically."[15]

Another factor contributing to lack of focus on the family is their inaccessibility — spouses of surgical patients are very busy people. For example, of the 102 spouses who met this study's criteria, 51 were not available for discussion the afternoon or evening before the patient's surgery. In addition to this spouses were frequently not available after the first postoperative day. Over a seven-month period of data collection, it became apparent that, because of the inaccessibility of spouses and their transient visiting patterns, nurses and spouses quite often occupied the same space — they just never met.

A Solution

In an effort to lessen the burden of isolation and anxiety for the spouses of patients undergoing surgery I developed a preoperative orientation program. This program described:

- the general pre-, intra- and postoperative nursing care of patients
- the role of the spouse and other health team members in caring for the patient
- the orientation of spouses to the hospital environment.

This information was laid out in a 10-page script and a 20-minute tape recording. Each spouse (and anyone else who was interested, including the patient) received the tape/script presentation simultaneously. They were also given a copy of the script to keep.

The preoperative orientation program included talking with spouses individually. It was at this meeting that I talked to them about procedures unique to their husband's/wife's surgery and answered their questions. The sessions were held the afternoon or evening before the patient's surgery. Each session averaged approximately 40 minutes, depending on the number and nature of the questions raised.

In order to give you some idea of the content and tone of the orientation program here are a few examples of information I presented to spouses in our tape/script production. (In these examples, "you" refers to the spouse).

— You may visit the patient at any time the day of surgery and accompany him to the doors of the operating room if you so desire.

— You should not judge the seriousness of the surgery by the time the patient is in the operating room. It is customary to send for patients some time in advance of the operation and preparations by the anesthesiologist take time.

— Following the operation, patients are transferred to the recovery room. The ratio of nurses to patients in a recovery room is high so that patients can be carefully and frequently observed while awakening from the anesthetic.

Obviously there is an overlap between this information and preoperative teaching information for patients, but there are also areas of difference. For example, although spouses are given an overview of how the patient is prepared for surgery, they are not given detailed explanations about how patients are coughed, deep breathed and turned. Rather, the focus is on letting the spouse know just how they can participate in the surgical experience and how they can communicate with health team members.

Evaluation

How did spouses respond to the orientation program? Of 48 spouses who participated in this study, 44 of them received the tape/script presentation. I asked these people how helpful they thought the presentation was.

Extremely helpful — 28 spouses
Considerably helpful — 12 spouses
Slightly helpful — 4 spouses
Not helpful — 0 spouses

Those spouses who found the tape/script "slightly helpful" said they had prior experience with surgery and felt most of the information offered was already familiar to them.

Others reacted more positively,

- "This is a terrific idea. You should mail the script to families ahead of time."
- "This information is very reassuring. It should be available to all spouses."

Several people told me that after they had seen the presentation they gave the script to others. Those 'others' included brothers, sisters, sons, daughters, parents, in-laws and even other patients and their families. One script turned up safely in the hands of a newly admitted patient a month after it had been given to a spouse in my study.

When I asked people what they found most helpful (or not helpful) about the program they told me it let them know what to expect and gave them an opportunity to receive new or review old information.

Specific information that spouses said they found most helpful included the patient's visiting hours on their day of surgery, how and where they could meet the doctor after surgery and how patients are cared for through a systematic team effort. Spouses who received the tape/script orientation program reported less anxiety and more favorable attitudes toward hospitalization and surgery than those who did not receive the program.

Some Practical Considerations

I found that this preoperative orientation program for spouses is neither time consuming to initiate nor costly to implement. In my case less than eight weeks passed from the time the program was first presented to the hospital administrator to the time the first spouse participated in it. During this period I received permission to conduct the study, wrote the script and produced the tape. The script was reviewed by 12 nurses, an administrator, a chaplain and an admitting supervisor before it went into production. The hospital already owned tape recorders, cassettes and copiers so the primary expense was the cost of reproducing the script for each spouse.

After the study was completed I shared the results with administrators, nurses and physicians. The primary concern expressed by all was, "How do we implement the program so that we reach the most spouses?"

The method that was selected included the following:

- Videotaping the preoperative orientation information and showing it on closed circuit television at 7 p.m. each evening.
- Telling spouses about the program by attaching a notice to each patient's dinner menu.
- Placing a copy of the written script on each unit for handy reference by patients, spouses and hospital staff.
- Informing all nursing staff about the objectives of the program and their role in helping spouses.

To date, spouses have reacted positively to the program, saying that it has helped them in coping with their patients.

If a concerted effort is made by administrators, nurses and other health team members, the family of the surgical patient can become actively involved in the surgical experience, and consequently, feel less afraid and alone.

Acknowledgement: *The author would like to thank the administration, staff and patients at Holy Cross Hospital in Silver Spring, MD., for helping to make this study possible.*

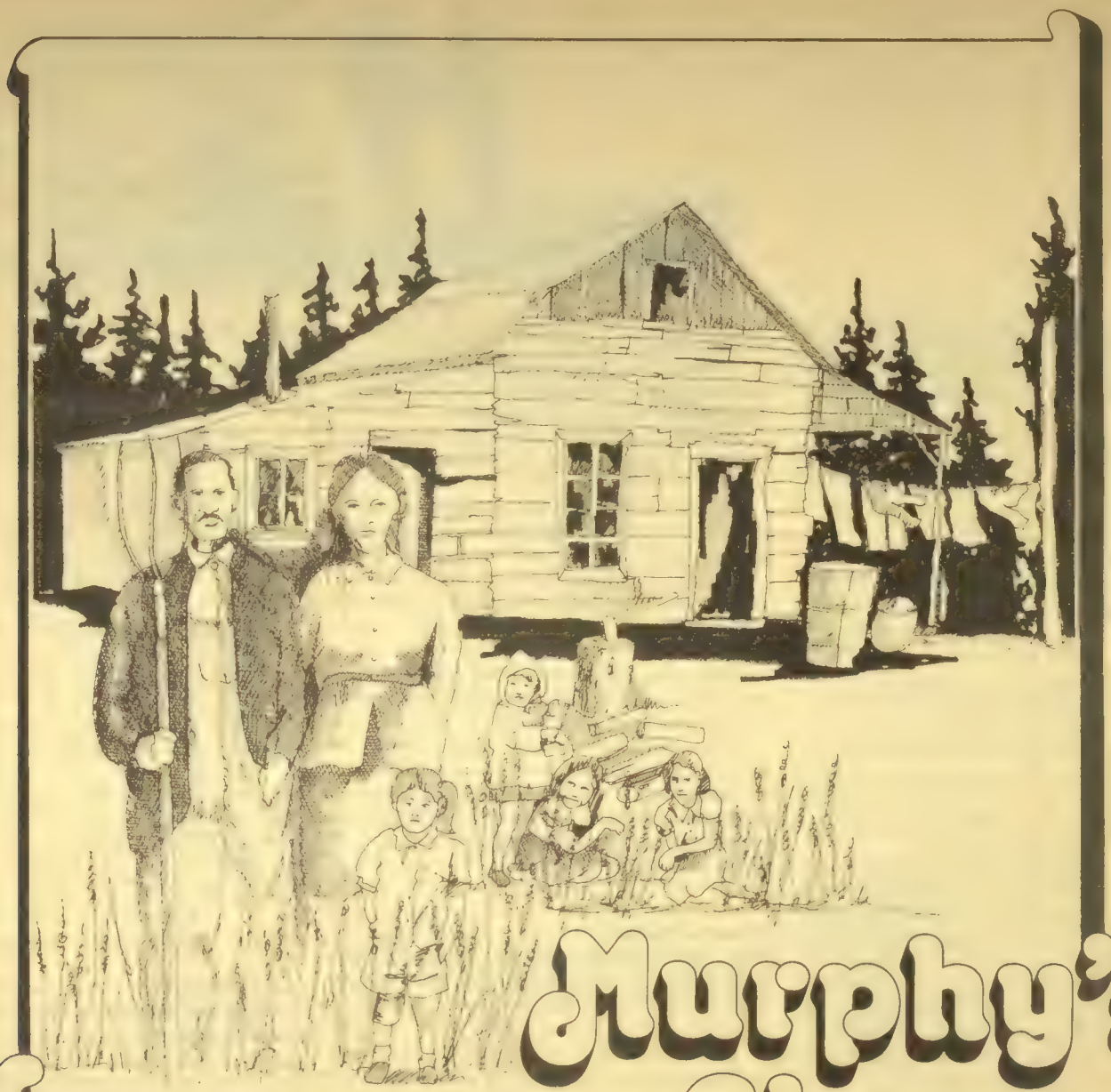
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"Spouses need nurses too" is an outgrowth of a doctoral dissertation by author, **Mary Cipriano Silva** *(R.N., St. Rita's Hospital School of Nursing, Lima, Ohio; B.S., M.S., Ohio State University; Ph.D., University of Maryland). At present, she is an associate professor of nursing at George Mason University, Fairfax, Virginia. Her previous experience includes teaching medical-surgical nursing at Stanford University School of Nursing and Frances Payne School of Nursing, Case Western Reserve University, Cleveland, Ohio.*





Murphy's Glue

Laura Hall

As a social worker, Mr. Duncan had seen a lot but now his six-foot frame was hunched dejectedly over his desk, bony fingers combing his iron gray hair.

I shuffled the thick file in front of me, gathering it into my briefcase as I rose to leave. We had just concluded discussing another crisis in the Murphy family.

"We can't separate them," Mr. Duncan exclaimed. "And you know why," he added, frustration surfacing in his Oxford accent.

Six months previously as a fledgling Public Health Nurse assigned to a rural district I had inherited the Murphy case file.

Members of the community termed the Murphy residence "a dirty fire trap" and an eyesore. Teachers at the local school presented a long list of complaints that included truancy, lack of adequate clothing and personal cleanliness, poor lunches, facial sores and other defects all attributable to the four school-age Murphy children between the ages of five and ten.

The bulging file I held spoke volumes in unresolved problems with continued Health Nurse assistance.

On my first visit, as I came in sight of their residence my mind registered, "write-off." With difficulty I manoeuvered my small car down the winding, rutted lane to the tar-paper shack.

I knocked at the dilapidated screen door which opened into their narrow, cluttered porch. Beyond the porch lay the main room containing a large round table,

rickety chairs and a shabby couch piled high with clothing. A crowded, dingy bedroom could be seen to the left of the main room. The cramped attic room was accessible only by a steep, narrow stairway. The entire house had a "certain air," namely stale food mixed with woodsy smoke from an old stove.

Looking round, I chose the chair that offered the least porridge remains. As I had suspected from neighborhood rumors, Mrs. Murphy was pregnant, about seven months I judged. Mr. and Mrs. Murphy had been assessed as slow learners and my enquiries met with typical unconcern.

As a practical gesture we made plans for a visit to the doctor and wrote out some simple meal plans. Evidence of accumulated soft drink bottles and empty potato chip cartons made the success of this exercise dubious.

My predecessor had instructed Mrs. Murphy in the use of a wringer washing machine donated to the family. On her next visit she had found the wash dutifully pinned to the line, wrinkles and all, just as it had rolled through the wringer — totally unshaken.

I limped along with the family until the Christmas surprise arrived — a new baby girl, born a week prior to Christmas day.

Mr. Duncan was now doling out food vouchers to Mr. Murphy, whose seasonal employment had hit a lull. "Make sure they buy some canned milk for the baby," Mr. Duncan advised before leaving the city for his vacation. He knew that the next food voucher might be diverted for admission to a movie or other family entertainment.

Three days following delivery, including a post-partum hemorrhage, Mrs. Murphy discharged herself from the hospital. "See if you can get a consent for sterilization and have her readmitted," the clinic doctor bellowed at me over the phone.

The next day, fighting my way along the snow-plugged roads enroute to the Murphys, I though wryly of the doctor's orders. I knew that Mrs. Murphy would put off the sterilization until her next pregnancy, so I'd better concentrate on the baby.

The Murphys all gathered around the table as I produced the donated baby tub for a demonstration bath. The heads of the two pre-school tots bobbed curiously above the magazines and papers at one end of the table. Mr. and Mrs. Murphy sat on the couch holding hands, a glow suffusing their faces.

Just as I finished demonstrating the baby bath, emphasizing the virtues of cornstarch as a good, cheap dusting powder, the door flew open and the children tumbled in from school.

They were met with hugs and kisses. Immediately, the lesson was forgotten while school work was admired and pinned to the wall. Each event of the school day was recounted in detail and listened to with rapt attention. Plans for supper consisted of a free-wheeling discussion about which can to open. The frozen bread, dropped at the lane entrance, was brought in by the children and put in the oven to thaw. A pail of jam plunked in the middle of the grubby table made an effective centerpiece. "We'll play Chinese Checkers after supper," I heard the children saying as I closed the door.

"It's futile, disgusting and hopeless," I thought, driving back to the city in the descending dusk. "The only remedy for that mess is a bomb."

Dimly in the back of my mind I thought of Mr. Duncan's words at our last meeting. "We can't separate the family and you know why" ...but was it enough? I could not dismiss the happy, enthusiastic faces of the children above their unkempt clothing and sensed in the choking, smokey atmosphere a warmth not generated by wood and fire.

Returning from my Christmas vacation a memo topped the litter on my desk. "Fire destroyed Murphy house, check with Mr. Duncan re placement of children."

It was the unanimous conclusion of all the organizations and individuals involved in looking after the Murphy family, that the fire was the best thing that could have happened — a blessing in disguise. The family had escaped unharmed and the children had been placed in district foster homes. We had a new lease in resolving our problems.

The new lease lasted about a month, until the first interview with the primary teacher and the principal at the local school took place.

The Murphy children simply were not blossoming as we had been sure they would. They were pale, not hungry for their "Canada Food Rule" lunches, and unimpressed by their new clothing. One or two were showing behavior problems undreamed of in pre-fire days.

Frustration and resentment characterized the reports I received from the foster parents in the homes where the Murphy children had been placed. They cried for their real parents and for each other. They did not appreciate the bright, clean decor of their new homes or their stiff new clothes. "What more can we give them?" was the repeated cry.

The new house that Mr. Duncan and I found for them was the "more" we settled on. Nevertheless, disgust was evident in my voice when I returned from my first visit to their new home and recounted the latest Murphy saga to Mr. Duncan. "I discovered an odorous Murphy baby in a basket on the floor — oiled and dusted, not with cornstarch, but with cake flour. They are hopeless and you are not very popular in the community for getting them back together."

"The house has one more room," Mr. Duncan countered, grinning at me.

"You are asking for a whole new string of problems," I replied.

"I didn't get them together," he said seriously. "It's the Murphy glue. We can't separate them, they care about each other. They love each other and it shows. It is the one thing that holds hope for them when nothing else does."

Murphy's glue, I thought, was pretty sticky stuff, stronger than good intentions and cornstarch.

Laura Hall, *the author of our "Christmas Story,"* ***Murphy's Glue,*** *is a freelance writer and member of the Canadian Authors' Association who describes herself as "a registered nurse on the inactive list." This story, one of several she has had published since she began her writing career, is based on her own experience while she was still practising.*

A graduate of Brantford General Hospital School of Nursing in Brantford, Ontario, she also attended a three-year course in Christian Education in Illinois, U.S.A. before completing her graduate work at the University of Western Ontario. After working as an assistant and head nurse in emergency and surgical nursing, she spent four years as a public health nurse in northern Ontario.

Now married to a high school teacher and living in Winnipeg, she is the mother of three children.

Resumes are based on studies placed by the authors in the CNA Library Repository Collection of Nursing Studies.

Research

- **Patient Classification**

The Development and Testing of an Instrument for Assessment and Classification of Patients by Types of Care. Saskatoon, Sask., 1976. Thesis (M.H.S.A.), University of Alberta, by *Mavis E. Kyle.*

The study was undertaken to develop and test an instrument for assessment and classification of patients by Types of Care. The project was initiated by the Medicine Hat and District Health Planning Committee as one method of identifying the needs of the community for health care programs and facilities, as well as describing the characteristics of the study population to show the appropriateness of present patient program-placement. The major objective of the investigator was to identify the degree of reliability and validity of data obtained by use of the instrument.

Using the Types of Care classification and related patient characteristics as defined in the *Report of the Working Party on Patient Care Classification* as the criterion measure, an assessment and classification instrument and User's Manual were developed. Assessment items were related to the demographic characteristics, medical status, and physical and psycho-social functioning of each patient. Classification items included the type of care, the site where needs could best be met, and program requirements.

Following a pilot test and pretest, a clinical analytical survey was carried out on a specific day on the study population of 490 patients in an acute care hospital, auxiliary hospital, two nursing homes and individuals awaiting placement in the long-term care facilities. The assessors were registered nurses in the institutions and in the community, providing care to the patients. Additional input from other health care professionals, the patient and his family was encouraged.

A stratified random sample of 100 patients was used for an inter-rater reliability study and another sample of 100 patients was randomly chosen for an empirical validity study. Statistical procedures were undertaken to identify the degree of reliability and validity of the instrument items and to produce descriptive frequency distributions.

It was concluded that the instrument possessed an acceptable degree of reliability and validity. The major recommendation is that additional research be undertaken to determine predictive validity and further refine the instrument and User's Manual. Other recommendations relate to the experimental use of information gained by studies of this kind for planning, administrative and patient care decision-making.

- **Education for Teachers**

Orientation and Inservice Programs for Teachers in Canadian Two-Year Schools of Nursing and Sources of Satisfaction and Dissatisfaction as Perceived by these Teachers. Fredericton, N.B., 1976. Thesis (M.Ed.) University of New Brunswick by *Betty Carol Field.*

Nursing education in Canada has experienced a definite change in the last ten years. Many traditional three-year hospital based nursing schools have been replaced by two-year educationally controlled schools of nursing. Orientation and inservice education programs for faculty members are in an early stage of development and no previous studies could be found concerning such programs in these schools.

This study was designed to obtain information concerning the orientation and inservice education programs provided for teachers in the two-year nursing schools across Canada. It was also designed to explore sources of satisfaction and dissatisfaction among faculty members in these schools, and to identify significant relationships, if any, between certain teacher characteristics and expressions of satisfaction with various aspects of their teaching positions.

Two questionnaires were constructed by the investigator to gather data for this study. The first questionnaire, designed to obtain information about faculty members, the orientation, and the inservice education programs provided for faculty members, was completed by 23 of the 40 directors of two-year educationally controlled nursing schools across Canada. The second questionnaire was designed to obtain information from faculty members about their qualifications, perceptions regarding their orientation and inservice education programs, and sources of satisfaction and dissatisfaction. It was completed by 102 of a random sample of 150 faculty members in these schools.

The content of responses to open-ended questions was analyzed by the investigator. Frequencies and percentages were tabulated on numerical data. It was found that:

- a period of orientation is generally provided for new teachers in the two-year programs
- these programs include various topics and range from under 10 hours to over 120 hours
- faculty members generally were not satisfied with the orientation they had received and specified areas they would have found helpful
- inservice education programs were provided for teachers in most of the schools
- various topics were covered in the past year and faculty involvement ranged from under one hour to over ten hours per month
- the majority of teachers expressed dissatisfaction with the inservice education programs and listed topics they would like included in future programs
- the majority of teachers were satisfied with working relationships with other faculty members, student contact, philosophy and objectives of the school, the clinical area used for student experience, salary, fringe benefits, library facilities, teaching aids, relationships with the school's director and assistants, teaching load, student teacher ratio, and freedom to schedule their own work time.
- in addition to orientation and inservice education programs, faculty members expressed dissatisfaction with the leadership and administration of the schools and methods of faculty evaluation.

Recommendations based on the findings in this study included the following:

1. The feelings of present faculty members regarding orientation and inservice education programs should be assessed and existing programs should be revised or supplemented in accordance with the expressed needs.
2. More extensive orientation should be provided for new teachers in relation to teaching methods, evaluation techniques, test construction, and faculty expectations for student performance at various levels.
3. Inservice education programs on educational topics, techniques of teaching and evaluation, curriculum development, and working with students should be available in the schools for faculty members. Teachers should be encouraged to attend available conferences on educational topics outside their own schools.
4. The areas of leadership or administration and methods of faculty evaluation (areas of dissatisfaction for many faculty members) should be explored.
5. The areas of curriculum, physical facilities, clinical areas, salary and fringe benefits (sources of satisfaction for some teachers and sources of dissatisfaction for others), should be evaluated in individual schools; steps should be taken to improve these areas or the understanding of these areas as applicable.

Implications for further research would include the following:

1. A similar study should be undertaken at a time when financial restrictions and the employment situation would be less likely to be a factor in influencing responses.
2. Similar studies should be conducted in regions or provinces of Canada to identify more clearly any regional trends and reasons for such expressions of satisfaction and dissatisfaction.
3. Further information should be obtained on the relationships between on-the-job preparation (in terms of orientation and inservice education programs) and (a) feelings of faculty satisfaction and (b) effectiveness of faculty members.

Did you know?
Nursing in Canada: Canadian Nursing Statistics 1976 is now available wherever government publications are sold. The publication presents basic distributions and cross-classification of socioeconomic characteristics of the nursing profession in terms of work setting, salaries, and education as well as related information. (A Statistics Canada publication, catalogue number 83-226, price $1.40 per copy.)

Books

Community health and nursing practice by Evelyn Rose Benson and Joan Quinn McDevett. Englewood Cliffs, N.J. Prentice-Hall, 1976.
Approximate price $11.50
Reviewed by Jean E. Innes, Associate Professor, Community Nursing, College of Nursing, University of Saskatchewan.

The content of this hard cover text with its purpose to focus on family health, will disappoint the concept-process oriented reader and practitioner of community nursing.

The book is organized into five units. In the first three units the authors attempt to lay the foundation for the practice of community nursing by setting out some concepts fundamental to community health and tracing the development of present day practice. Traditional concepts of health and prevention are presented and some consideration is given to community health science concepts.

Definitions and discussions concerning the role of community nursing, nurse practitioners and nursing as a positive force in community health appear shallow, sketchy and misleading in terms of complexity unless the reader earnestly pursues the content of the bibliographies and glossaries listed at the end of each chapter of the unit. The first three units lack an overall conceptual framework to give the reader a feeling of continuity and wholeness. Perhaps the authors would have achieved this purpose better had they included concepts of systems and community as basic concepts to community health rather than introducing them later in the text as concepts related only to nursing intervention. Discussion of health problems, trends and populations at risk would have formed a more natural outcome from these units and lead directly into nursing intervention theory and method.

In the units set out to describe nursing intervention, the emphasis is on content rather than process. There is an absence of the quality of completeness in the discussions of the community and the family as a system, outcomes of crisis theory and intervention. and models for health education. The accomplished reader will question the superficiality of the presentation and the sequencing and integration of the concepts in these units.

The final unit deals almost entirely with the problem oriented system and nursing process. This unit may be useful to some readers in community nursing who are looking for a method for the compilation of a family data base and a method to formulate a problem list. Other readers will argue the illness oriented base of the problem oriented record system as it is presented in this text. The community nursing process again gets quick overview without note of the complexities involved with each step of the process, particularly as it relates to family centered community nursing.

The sample forms that appear throughout the text may attract some readers and be quite useful in applicability. The bibliographies are comprehensive and supportive of concepts presented in the text and must be read if the reader is a novice to the field.

Some readers may find the simultaneous use of the terms public health and community nursing puzzling; however, the sophisticated reader will have no problem making the necessary transition of terms.

This text might be used as a reference text by experienced readers and practitioners who are already familiar with the basic concepts, content and process of community nursing. I cannot agree that the authors have achieved their purpose of producing a book that focuses on family health or presents an approach that is family-centered.

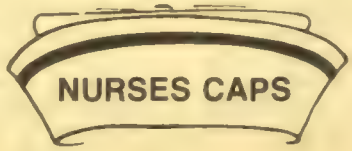
In my opinion the book fails to present the basic concepts in sufficient depth to achieve the objectives of the book.

Community health nursing by Kathleen M. Leahy, Marguerite Cobb and Mary C. Jones. 3d ed. Scarborough, McGraw-Hill, Ryerson, 1977.
Approximate price $13.15
Reviewed by Jennifer Carryer, Lecturer, School of Nursing, University of Manitoba, Winnipeg, Manitoba.

"Community Health Nursing" is intended as a comprehensive introduction for nursing students in the area of community health. The text is very readable, with simple cartoons and diagrams as well as current bibliographies accompanying each chapter.

One chapter outlines ways that theories of developmental process, learning process and socialization process can form a frame of reference for application of the nursing process with individuals and families. Another chapter deals with

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Books

therapeutic communication skills, and the teaching-learning principles most necessary in community nursing.

The book explores the application of the nursing process with families as well as communities and continually emphasizes the aspect of mutual goal setting with clients. Not only does it provide a conceptual framework and overview of community health nursing, but it also aids the beginning student in dealing with very practical situations such as case finding, consulting, referring, and recording client interactions.

Other chapters cover the topics of working with groups, preventive health care, aging and trends in health care delivery. This edition includes a vastly updated chapter on epidemiology, elementary statistics and research. It integrates these concepts in a manner that would be meaningful to a student or beginning practitioner in a community setting.

Part II of the book includes a case study of program planning, from identification of the need to initiation of the program. Also included are case studies to demonstrate the application of various theories including the social learning theory, Maslow's hierarchy of human needs etc., in specific client situations. There are 10 situational exercises on family visiting and three on community assessment that would benefit nursing students.

Although many references are made to American organizational structure and resources, these do not detract from the principles that they illustrate.

The Mentally Retarded and Society; A Social Science Perspective edited by Michael J. Begab and Stephen A. Richardson, Maryland, University Park Press, 1975.
Approximate price $17.50.
Reviewed by Anne Marie Kelly, Instructor in Nursing, Halifax Infirmary School of Nursing, Halifax, Nova Scotia.

This book originates from a conference sponsored by the National Institute for Child Health and Human Development and the Rose F. Kennedy Foundation Center for Research in Mental Retardation and Human Development. It addresses "some of the major issues of social concern and policy posed by the mentally retarded in our society." In the preface, the editors speak of mental retardation " ... as a social problem that varies from culture to culture..." and they state that " ... society perceives as retarded those who fail to measure up to its norms, expectations and demands because of presumed intellectual inadequacies."

It is around these statements that the book is organized into 22 articles, background papers and discussions. Because of the number of articles, it is easier to discuss the book by dealing with the six topic groups under which the articles are presented.

- Historical and Contemporary Issues: This topic deals with the status of the mentally retarded in present day society, a historical perspective of their status throughout the past, and briefly, some contemporary issues. Stein and Susser's article deals specifically with the incidence and prevalence of mental retardation in society today.
- The section on Attitudes and Values includes Gottleib's public; peer and professional attitudes toward the retarded and Mercer's pointed article about the erroneous assignment of lower I.Q. scores to children of a minority group.
- Three articles under the topic of Social Competence and Socialization deal mainly with the language and social skills necessary for integration of the retarded in society.
- Forms of Family Adaptation : The presence of a mentally retarded family member adds stress to normal family roles. Farber's article deals with the phases a family goes through in order to cope with the situation. This section includes discussions on deinstitutionalization and its effect on the family, and foster family care — its benefits, problems involved, and the type of family best suited to foster care. Garber's account of the Milwaukee project — a study of children with low IQ's and the socioeconomic class in which they are raised — also appears in this section of the text.
- Emerging Patterns of Service for Young People and Adults: Most of the articles in this secton deal with residential vs. hospital care and with vocational adjustment of the mentally retarded as, through public advocacy and other means, full human rights are sought for these people.
- Social Change — Problems and Strategies: includes discussions of the legal, technical and bureaucratic problems occurring with the change of status of the mentally retarded. Also included is a discussion of how attitudes of teachers, nurses and media can be changed. Etzioni and Richardson's article pleads the case of planned and guided change, change that has been prepared with a view to prevention of suffering for the mentally retarded.

This book is an excellent resource for those interested in the role of the mentally retarded in present day society. The articles are pertinent and up-to-date, the authors knowledgeable, and the material interesting. The book, however, contains very little clinical data, being, as the title indicates, psychosocial in make-up — ' a social science perspective.'

Because of this, the book would prove of little value to students in a diploma program, because of the depth of subject matter and the way it is presented. Many of the articles are deeply couched in psychological and sociological terms. Therefore those lacking a good background in statistics — means, modes and standard deviations — would not be able to properly interpret the data presented. It is an excellent book for those involved in the field of mental retardation and for those who have a strong psychosocial and statistical background needed to property understand and interpret the articles.

Adult and child care; a client approach to nursing 2d ed. by Janet M. Barber, Lillian Stokes and Diane McGovern Billings. 1036 pages. St. Louis, Mosby, 1977.
Approximate price $18.95
Reviewed by Eileen Burrows, coordinator, diploma nursing program, Centennial College of Applied Arts and Sciences, Scarborough, Ontario.

The authors have devoted considerable thought and effort to the revision of their nursing text. In this second edition, the integrated approach to the nursing care of adults and children has been maintained and improvements have been made in relation to several areas of content which were incomplete in, or missing from, the first edition.

The content is organized in a manner which is compatible with the approach to the teaching of nursing inherent in many basic nursing programs. The focus is on basic human needs throughout the life cycle, and the common health problems resulting from stress and stressors, of clients of all ages. Assessment, intervention and instruction, as components of the nursing process, are presented in relation to normal needs and the common health problems. This integration of content makes it easier for the learner to understand how the nursing process is utilized in a wide variety of situations.

Several areas of this edition have been significantly expanded from the first edition. Greater emphasis has been placed on explanation of pathophysiology and rationale for nursing interventions. Sections on pathophysiological and psychosocial considerations have been added to the discussion of each need. Additional content in areas such as tumors, fluid and electrolyte imbalance and shock provide the type of information required to make sound nursing judgments. Perhaps the most beneficial addition to the text is the greater emphasis placed on the assessment phase of the nursing process. Client assessment is emphasized in all areas, and several useful assessment guides have been included.

The area of the text pertaining to the child client has not been significantly altered. Perhaps this area might have benefited from the same thoughtful revisions given other aspects of the text. Application of concepts of growth and development, and the rationale for nursing care related to some health problems particular to children might be presented in more detail.

The authors state that this text has been developed for the basic undergraduate student who is learning about the nursing care of adults and children. This text would be very appropriate if the client were an adult; additional basic resources would be necessary in some cases if the client were a child. However, the manner in which the content is integrated to emphasize the utilization of the nursing process, and the quality of much of the material presented, makes this an excellent resource book

Library Update

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Clinical Wordsearch

Answers

Puzzle no. 9 (appears on page 37)

1 Head
2 Meningeal
3 Spinal Cord
4 Paralysis
5 Synapse
6 Axon
7 Chorea
8 Demyelinating
9 Dermatome
10 Brain Abscess
11 Skull
12 Subdural Haematoma
13 A.L.S.
14 Syringomyelia
15 Spina Bifida
16 Clonic
17 Myelogram
18 Myasthenia Gravis
19 Concussion
20 Seizures
21 Medulla
22 Pons
23 Alzheimer's
24 Myelin Sheath
25 Herpes Zoster
26 Reflex
27 Nerve
28 Aphasia
29 Gyrus
30 Frontal Lobe
31 C.V.A.
32 C.S.F.
33 T.I.A.
34 Tonus
35 Stupor
36 Coma
37 Pupils
38 Autonomic

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General Duty Nurses for modern 41-bed hospital located on the Alaska Highway. Salary and personnel policies in accordance with RNABC. Accommodation available in residence. Apply Director of Nursing, Fort Nelson General Hospital, P.O. Box 60, Fort Nelson, British Columbia, V0C 1R0

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Position available immediately.

Interested applicants are asked to reply, in confidence, stating salary expected and including curriculum vitae, to:

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Canadian Nurses Association
Testing Service
Suite 400, 220 Laurier Avenue West
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The Director of Nursing
Mrs. Jean M. Moore, FCNA.
Royal Hobart Hospital
Box 1061L, G.P.O.
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Stratford, Ontario
N5A 2Y6

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McMaster University
Health Sciences Centre
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